MUST BE COMPLETED EACH SCHOOL YEAR

Emergency Medical Information for 2019-2020 School Year

LAKE TAHOE SCHOOL

Child's Name _____ Grade: _____

Mother's Name _____ Mother's cell _____ _____

Father's Name _____ Father's cell _____

Emergency Contacts other than parents:

1. Name_____ Relationship_____ Cell_____
2. Name_____ Relationship_____ Cell_____

Last Dental Exam date__ _____ Dr. _____

Primary Physician_____ Phone_____

DOES YOUR CHILD HAVE…?

Allergies: Medical/Food/Other	No ___	Yes ___	Specify _____
Anorexia/Bulimia	No ___	Yes ___	Specify _____
Asthma	No ___	Yes ___	Mild/Moderate/Severe (circle one) Specify _____
Blood Disorder	No ___	Yes ___	Specify _____
Cancer	No ___	Yes ___	Specify _____
Depression	No ___	Yes ___	Specify _____
Diabetes	No ___	Yes ___	Specify _____
Ear Infections	No ___	Yes ___	Specify _____
Epilepsy or Seizures	No ___	Yes ___	Specify _____
Heart Condition	No ___	Yes ___	Specify _____
Insect/Bee Sting Allergy	No ___	Yes ___	Specify _____
Kidney Disease	No ___	Yes ___	Specify _____
Migraines	No ___	Yes ___	Specify _____
Orthopedic Problem	No ___	Yes ___	Specify _____
Ulcers	No ___	Yes ___	Specify _____
Other	No ___	Yes ___	Specify _____

HAS YOUR CHILD HAD…?

Serious Illness	No ___	Yes ___	Specify Type & Date _____
Serious Injury	No ___	Yes ___	Specify Type & Date _____
Surgery (Operations)	No ___	Yes ___	Specify Type & Date _____

DOES YOUR CHILD HAVE…?

Trouble Seeing Close Work	No ___	Yes ___
Trouble Seeing at Distance	No ___	Yes ___
Trouble Hearing	No ___	Yes ___

DOES YOUR CHILD?

Wear Glasses	No ___	Yes ___
Wear Contacts	No ___	Yes ___
Wear Hearing Aid	No ___	Yes ___

Does your child have a condition which prevents participation in regular P.E. or other outdoor education (running, push-ups, wrestling, contact sports, hiking, etc.)? No ___ Yes ___ Specify _____

Does he or she take daily medication? No ___ Yes ___ Specify _____

Will your child need to take medication during school hours? No ___ Yes ___ If yes, specify _____

Does your child have any medical or physical restrictions? No ___ Yes ___ If yes, specify _____

This child's last physical exam was _____ and she/he is deemed healthy and may attend school.

Physician Signature: _____ Date: _____

Medical Release: When I/We cannot be located after reasonable efforts, under the circumstances, the Head of School (or her representative) is authorized under NRS.129.040, but not required, to seek medical care for the above named student, in case of serious illness, accident, or other emergency requiring immediate hospitalization, medical attention, or surgery. I authorize any qualified LTS employee, volunteer or medical personnel to render necessary emergency care for the above named student. I/We also agree to be responsible for all medical costs incurred on the student's behalf.

Medical Insurance Provider:_____ Policy#:_____

Parent or Legal Guardian's Signature:_____ Date:_____

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