

MUST BE COMPLETED EACH SCHOOL YEAR

Emergency Medical Information for 2017-2018 School Year



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: _____