New Lexington City Schools
EMERGENCY MEDICAL AUTHORIZATION

In case of an emergency, the school staff will contact 911. Every attempt will be made to contact a parent/guardian, or a listed emergency contact.

STUDENT'S LAST NAME _____ FIRST _____ MI _____ SEX (M F) _____ DATE OF BIRTH _____

DATE OF LAST PHYSICAL EXAM: _____ DATE OF LAST DENTAL EXAM: _____

I. STUDENT HEALTH CONDITIONS:

☐ **NO medical conditions/Hospitalizations** ☐ **YES, child has the following conditions** or has had a Hospitalization

____Abnormal spinal curvature (scoliosis, etc.)	____Cystic Fibrosis	____Menstrual problems
____Allergies or hay fever (list below in section III)	____Depression	____Neuromuscular disorder
____Asthma	____Diabetes	____Seizure disorder
____ADD/ADHD	____Ear problem/hearing difficulty	____Sickle Cell disease
____Autism	____Emotional Concerns	____Skin conditions
____Behavior concerns	____Headaches (frequent)	____Speech problems
____Birth or congenital malformation	____Heart Problems	____Traumatic brain injury
____Bone/muscle/joint problems	____Hemophilia	____Vision problems (glasses,contacts)
____Blood problems	____Hepatitis	____Other_____
____Bowel/bladder problems	____Juvenile arthritis	____Other_____
____Cancer, Type_____	____Lead Poisoning	____Other_____

Please explain any conditions above or any reasons for hospitalizations: _____

II. VISION AND HEARING

When was last eye exam done by eye doctor? (approximate date or "never")_____ Wears glasses/contacts (circle)?

Frequent ear infections? Yes / No If yes, were tubes placed? Yes / No Are tubes still in place? Yes / No Is there a hearing loss? Yes / No / Don't know

III. Allergies Please indicate any allergies child may have. ☐ NO KNOWN ALLERGIES **NOTE: Special Forms Required for Medications that must be administered at school.**

Allergy type	Reaction	Treatment/Recommended Actions/School Restrictions
☐ Bee/Insect (type)		
☐ Food (list)		
☐ Medication (name)		
☐ Other (list)		

IV. MEDICATIONS Please list any prescription and over the counter medications that child takes on a regular basis **NOTE: Special Forms Required for Medications that must be administered at school.**

Medication and dose	Time	Reason

V: Do any health and/or medical conditions require school restriction, modifications, and/or intervention? ☐ Yes ☐ No If YES, please explain.

_____

VI: Does the student require any special procedures and or treatments for their health condition? ☐ Yes ☐ No If YES, please explain.

_____

VII: Please indicate any other information about child's health or development that you think would be helpful for the school to know.

_____

_____

PHYSICIAN / DENTIST INFORMATION		
My child's medical care is provided by:	Telephone:	☐ any available
My child's dental care is provided by:	Telephone:	☐ any available

Sign Either The Consent or The Refusal, but NOT BOTH!! **Sign Either The Consent or The Refusal, but NOT BOTH!!**

Consent

The school **DOES HAVE** *my permission, in case of an emergency when I cannot be contacted, to take my child to the emergency room or the nearest hospital, and the hospital and its medical staff have my authorization to provide treatment that a physician deems necessary for the well-being of my child.*

Parent or Guardian Signature: _____ Date: _____

Refusal

The school **DOES NOT HAVE** *my permission, in case of an emergency when I cannot be contacted, to take my child to the emergency room or the nearest hospital.* ***The school should follow the instructions I have listed on the back side of this sheet.***

Parent or Guardian Signature: _____ Date: _____

Sign Either The Consent or The Refusal, but NOT BOTH!! **Sign Either The Consent or The**