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, a guardian, or a designated emergency contact.

STUDENT INFORMATION	BUS # AM _____ PM _____

Last:	First:	Middle:
Date of Birth:	Gender: ☐ M ☐ F	Building: ☐ HS ☐ MS ☐ NLE ☐ JCE

HEALTH INFORMATION

Below check any current health condition that may require attention during the school day:

☐ Foods ☐ Asthma ☐ Cancer
☐ Diabetes ☐ Seizures ☐ Hearing problems / Hearing aid(s)
☐ Medicines (be specific): ______________________________
____
☐ Bee sting or insect bite: ______________________________
____
☐ Heart problems (be specific): ______________________________
____
☐ Physical disability (be specific): ______________________________
____
☐ Respiratory (be specific): ______________________________
____
☐ Vision problems (be specific): ______________________________
_____ glasses _____contacts
☐ Other (be specific): ______________________________
☐ Allergic Reaction to: ______________________________

List all medications and dosages your child receives on a continual basis:

CONTACT INFORMATION

Student resides with: (x) ☐ Father ☐ Mother ☐ Step-Parent ☐ Guardian

Any parent with whom the child resides has the right to make decisions concerning the child in the event of an emergency and to pick up the child from school, unless a court order or other legal document states otherwise. It is your responsibility to provide a copy of that document to your child's school.

☐ Father ☐ Guardian Last Name:	First Name:	Middle Int:
Address:		
Home Phone:	Work Phone:	Cell Phone:
Email:		
☐ Mother ☐ Guardian Last Name:	First Name:	Middle Int:
Address: ☐ same		
Home Phone: ☐ same	Work Phone:	Cell Phone:
Email:		

Please list three persons we may call if the parent(s) or guardian cannot be reached who have your permission to make decisions concerning your child in the event of an emergency. Please check the box if this person also has your permission to pick up your child from school.

Name of Person	Relationship	Telephone
	☐	
	☐	
	☐	

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

The school has 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: ____________________