New Lexington Schools
EMERGENCY MEDICAL AUTHORIZATION (EMA)
In case of 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	M F SEX	DATE OF BIRTH
_____	_____	___		_____

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

I. STUDENT HEALTH CONDITIONS:

____ **NO** medical conditions ____**YES**, child has the following conditions or has had a hospitalization

___ Abnormal spinal curvature (scoliosis, etc.)
___ Allergies or hay fever (list below is Section III)
___ Asthma
___ ADD/ADHD
___ Autism
___ Behavior concerns
___ Birth or congenital malformation
___ Bone/muscle/joint problems
___ Blood problems
___ Bowel/bladder problems
___ Cancer, Type _____
___ Cystic Fibrosis
___ Depression
___ Diabetes
___ Ear problems/hearing difficulty
___ Emotional concerns
___ Headaches (frequent)
___ Heart problems
___ Hemophilia
___ Hepatitis
___ Juvenile arthritis
___ Lead poisoning
___ Menstrual problems
___ Neuromuscular disorder
___ Seizure disorder
___ Sickle Cell disease
___ Skin conditions
___ Speech problems
___ Traumatic brain injury
___ Vision problems
___ Other _____
___ Other _____
___ Other _____

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

II. VISION AND HEARING:
When was last eye exam done by an eye doctor? (Approximate date or "never")_____Wears glasses/contacts (circle)
Frequent ear infections? **Yes or No.** If yes, were tubes placed? **Yes or No.** Are tubes still in place? **Yes or No.**
Is there hearing loss? **Yes or No.**

III. ALLERGIES: Please indicate any allergies child may have. ____ **NO KNOWN ALLERGIES**

Allergy Type	Reaction	Treatment/Recommended Action/School Restriction
Bee/Insect (type) _____	_____	_____
Food (list) _____	_____	_____
Medication (name) _____	_____	_____
_____		
Other (list) _____	_____	_____

IV. MEDICATIONS: Please list any prescriptions and over the counter medications that child takes on a regular basis. Please include medication name and dose, time taken, and reason. **NOTE: Special forms required for medications that must be administered at school.**

_____
_____

V. Do any health and/or medical conditions require school restriction, modifications, and/or interventions? **YES or NO.** If yes, please explain _____

VI. Does the student require any special procedures and/or treatments for their health conditions? **YES or NO.** If yes, please explain:
_____

VII. 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!

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 its medical staff have my authorization to provide treatment that a physician deems necessary for the well-being of my child.
PARENT/GURADIAN 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 on the back of this form.**
PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

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. **We will assume these persons may also pick up your child from school.**

Name:_____**Relationship**_____

Cell number_____**Other number**_____

Name:_____**Relationship**_____

Cell number_____**Other number**_____

Name:_____**Relationship**_____

Cell number_____**Other number**_____