PLEASE CHECK THE FOLLOWING ITEMS IF THEY PERTAIN TO YOUR CHILD

Check here if there are no known health problems☐

EYES

Wears glasses/contacts☐ To be worn at all times☐

EARS

Has a hearing problem☐ Has tubes in ears☐ Uses hearing aid☐

Requires preferential seating☐

GENERAL HEALTH

1. Has the following condition(s): Seizures☐ Fainting Spells☐ Diabetes☐
   Heart Condition☐ ADHD/ADD☐ Migraines☐ Asthma☐ Other☐
   Describe:_____
   _____
   Allergic reaction to bee stings☐ describe: _____
   Medication allergies☐ describe: _____
   Are any of the above life threatening?☐ _____

2. List medication prescribed:
   Name and dosage: _____
   For (diagnosis): _____
   Does the drug need to be taken during school hours?☐ _____
   Prescribed by Dr. _____ Phone _____

Note: Your student must have a doctor's note on file in the Nurse's Office in order to take any medication (including over-the-counter, i.e. Tylenol), at school or on field trips.

Under care of Dr._____ Phone _____

In the event of an emergency, if a parent or guardian cannot be reached, I hereby give my permission for the school authorities to render first aid and when deemed necessary, secure medical help or ambulance service at my expense.

As a legal custodian of _____, a minor, I hereby authorize the principal or his/her designees, into whose care the aforementioned minor pupil has been entrusted, to consent to any x-ray, examination, anesthetic, medical diagnosis, treatment, and/or hospital care to be rendered to said minor upon the advice of any licensed physician and/or dentist.

I understand that this authorization is given in advance of any required diagnosis, treatment, or hospital care and provides authority and power to the aforementioned agent(s) to give specific consent to any and all such diagnosis, treatment, or hospital care which a licensed physician or dentist may deem necessary.

This authorization shall remain effective for the full school year unless revoked in writing and delivered to said agent(s). I understand that the Nevada Joint Union High School District, its employees and its Board assume no liability of any nature in relation to the transportation or treatment of said minor. I further understand that all costs of paramedic transportation, hospitalization, and examination, x-ray, or treatment provided in relation to this authorization shall be my responsibility.

I understand that the Nevada Joint Union High School District does not provide accident medical insurance for students for school related injuries but does offer the student accident insurance for voluntary purchase. I have received the information and application for this program.

I understand the information given on this card will be used as a permanent guide for emergency care for my child and it is my responsibility to notify the school of any change.

Please check one:

☐ I have read the above statements and agree.

☐ I do not choose the above statement and desire the following action in the event of an emergency:

_____

Parent/Guardian Signature _____ **Date:** _____