

**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

**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:** \_\_\_\_\_