AAE/NSLA EMERGENCY INFORMATION CARD
Updated Annually

Student Full Name:_____

Grade: _____ Birth Date: _____ Sex ☐ Male ☐ Female

Address: _____ City: _____ Zip: _____

Authorization to Treat Minor

I (we) the undersigned parent(s), or legal guardian of the mentioned minor, do hereby authorize and consent to any x-ray, examination, anesthetic, medical or surgical treatment rendered by any member of the medical or emergency room staff licensed under the provisions of the Medical Practice Act, or a Dentist licensed under the provisions of the Dental Practice Act, and on the staff of any acute general hospital holding a current license to operate a hospital from the State of California Dept. of Public Health. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care deemed advisable by the aforementioned physician in the exercise of his best judgment. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that none of the above treatment will be withheld if the undersigned cannot be reached. This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California. In an emergency, a copy of this form may be given to local rescue/disaster personnel under federal guidelines of the *Family Educational Rights and Privacy Act (FERPA)*

Parent Information: ***Please indicate if parent is a step-parent, guardian or not in the home.***

If birth parent is not living in the home, may they be contacted in an emergency? Yes No

Mother/Guardian Name: _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Work Phone _____ Ext._____

Parent in the home yes/no **Please circle BEST # to contact first in an emergency.**

Father/GuardianName:_____

Home Phone: _____ Cell Phone: _____

Employer: _____ Work Phone _____ Ext. _____

Parent in the home yes/no **Please circle BEST # to contact first in an emergency.**

BEST EMAIL FOR SCHOOL COMMUNICATIONS: _____

In the event my child needs to be picked up early from school and I cannot be Reached, the listed names below have my permission to pick up my child. Please circle BEST # to contact during normal school day.

1st contact: _____ **Relationship:** _____

Home Phone: _____ Mobile Phone: _____

Work Phone: _____ Ext: _____

2nd contact: _____ **Relationship:** _____

Home Phone: _____ Mobile Phone: _____

Work Phone: _____ Ext: ____

3rd contact: _____ **Relationship:** _____

Home Phone: _____ Mobile Phone: _____

Work Phone: _____ Ext: ____

4th contact: _____ **Relationship:** _____

Home Phone: _____ Mobile Phone: _____

Work Phone: _____ Ext: ____

Medical Issues/Medications/Allergies: PLEASE COMPLETE FORM ON BACK

Does your child have any dietary concerns? ___ Yes ___ No **If yes, see reverse & contact the District Nurse at Ext 298.**

Local Physician: _____ Phone: _____ Insurance Company:_____

Local Hospital (circle one) St. Mary' Victor Valley DVMG Policy Number: _____ Medi Cal Eligible? _____

I give permission for treatment of my child in a medical emergency by a qualified physician in the event I cannot be reached at one of the above phone numbers.

Signed: _____ **Date:** _____

AAE/NSLA
HEALTH HISTORY

Please complete if NEW student **Check box ONLY if NO CHANGE from previous year.** ☐

Student's Name_____ Birthdate:_____ Grade____

1. Does the student have a physical problem which would need attention or any medication during school hours? ☐ Yes ☐ No If yes, list medications and dosage or other explanation.
   _____
   _____
2. Does your student take any medication at home ☐ Yes ☐ No
   Please list medication & dosage _____
   _____

   All medications given or carried at school must have a MEDICATION form (a special medication/orders form for diabetes) completed and signed by the prescribing physician and parent. M**edication must be in the original prescription container or as sold over the counter by the manufacturer. The medication form is available in the office or on line.**
3. Is the student able to participate in all physical education activities☐ Yes ☐ No

   If the answer is N0, please request and attach a physician's statement explaining the reason and specify exactly what activities cannot be done. **A school form also available.**
4. Please check the following & provide additional information on another sheet if necessary:

Student's Medical Conditions

Peanut/Nut Allergy	☐ Yes ☐ No	Epi Pen	☐ Yes ☐ No
Bee Sting Allergy	☐ Yes ☐ No	Epi Pen	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Inhaler	☐ Yes ☐ No

Diabetic	☐ Yes ☐ No	Wear glasses or contact lenses?	☐ Yes ☐ No
Epileptic	☐ Yes ☐ No	Color Vision Deficiency	☐ Yes ☐ No
Scoliosis	☐ Yes ☐ No	Orthopedic issues	☐ Yes ☐ No
Penicillin Allergy	☐ Yes ☐ No	Other Drug Allergy	☐ Yes ☐ No _____
Food Allergy	☐ Yes ☐ No _____	Other (*please explain)*	☐ Yes ☐ No

_____

Explanations or comments:

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