JLCD-E1

Student I.D. #_____ Bus #_____

EMERGENCY MEDICAL CARD

Please Complete and Return Immediately

Las Cruces Public Schools – Confidential Student Medical Information

Purpose: To enable parents or guardians to authorize emergency treatment for children who become ill or injured while under school authority, when parents cannot be reached. Upon completion, parents must return this form to the school. The original form and any copies thereof may be used to identify the medical options of the undersigned parent/guardian.

School _____ **Grade** _____ **Teacher** _____

_____

Student's Name (Last) (First) (M.I.) Date of Birth

_____

Street Address City Zip Code

_____

Mailing Address City Zip Code

_____

Father's/Guardian's Name Work Place/.Phone Cell Phone Home Phone

_____

Mother's/ Guardian's Name Work Place Phone Cell Phone Home Phone

Which individual is to be called first? _____

List, in the order you want them to be called, three relatives/ friends who will assume responsibility for your child until you can be reached.

_____

Name Relationship Bus. Phone Cell Phone HomePhone

_____

Name Relationship Bus. Phone Cell Phone Home Phone

_____

Name

Names of children living at home or attending Las Cruces Public Schools

1. _____ DOB_____ School_____
2. _____ DOB _____ School_____
3. _____ DOB _____ School_____
4. _____DOB _____School_____
5. _____DOB _____School_____
6. _____DOB _____School_____

Note: Parents/guardians are responsible for notifying the school nurse *and* school secretary about any change of information contained on this form.

EMAIL ADDRESS_____ **(optional)**

COMPLETE OTHER SIDE⟶

Revised 10/2016

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FACTS CONCERNING THE STUDENT'S MEDICAL HISTORY

1. Please indicate if student **is CURRENTLY** under treatment for any of the following conditions:

Hematological	(☐Yes ☐No)	**Psych/Mental Health**	(☐Yes ☐No)	**Genital-urinary**	(☐Yes ☐No)
Dermatological	(☐Yes ☐No)	**Asthma**	(☐Yes ☐No)	**Ear, Nose, Throat**	(☐Yes ☐No)
Heart Problems	(☐Yes ☐No)	**Respiratory, not asthma**	(☐Yes ☐No)	**Eye Problems**	(☐Yes ☐No)
ADD/ADHD	(☐Yes ☐No)	**Gastro-intestinal**	(☐Yes ☐No)	**Endocrine** (other than diabetes)	(☐Yes ☐No)
Neurological	(☐Yes ☐No)	**Congenital/Genetic**	☐Yes ☐No)	**Diabetes** (If yes, circle type I or II)	☐Yes ☐No)

If yes to any of the above, please describe_____

Serious Drug Allergy (☐Yes ☐No) If yes, explain: _____

Life-Threatening Food Allergy (student requires emergency medications at home and at school) ex: Epinephrine auto injector ☐Yes ☐No)

If yes, List allergen: _____

Emergency medications prescribed: _____

Non-Life-threatening food allergy: (☐Yes ☐No) If yes, what food: _____Reaction: _____

2. Does the student wear glasses/contacts? (☐Yes ☐No) Glasses/contacts worn: All the time Reading only Distance only

3. Does the student require any medications **DURING SCHOOL?** (☐Yes ☐No) **Please see Student/Parent Handbook**
Medication(s): _____

Does the student take daily medications **AT HOME?** ☐Yes ☐No) If **YES**, **please list** below.

1. _____ 2._____ 3. _____

4. Has the student been hospitalized for any serious illness, surgery or accidents **in PAST YEAR**: ☐Yes ☐No)
If **YES**, **please list**:

1. _____ 2. _____ 3. _____

5. Please list **ANY OTHER CURRENT** medical conditions you feel the school nurse should be aware of that are not listed above**.** Conditions such as, but not limited to: dental, eating disorder, migraine headaches, cancer, seizures, musculo-skeletal, seasonal allergies and pregnancy.

1. _____ 2. _____ 3._____

***Please see the school nurse if you answer YES to any of the above.**
***Unless otherwise notified, this information may be shared with other staff as appropriate.**

_____Phone _____
Health Care Provider

_____Phone _____
Dentist

Hospital Preference: □ Memorial Medical Center ☐Mountain View Regional Medical Center

Insurance Information: Please check all that apply:
☐Health Insurance ☐Medicaid Medicaid ID #_____ ☐No Insurance ☐School Insurance

If service involving medical action or treatment is required, school authorities will obtain medical service and/or transport the student. Reasonable efforts, under the circumstances, will be made to contact the parent/legal guardian for the purpose of obtaining consent. Nothing in this section shall be construed to impose liability on any school official or school employee who, in good faith, attempts to comply with this section. It is understood that the parent/guardian will be financially responsible for all emergency care, including EMS transport.

Signature of Parent/Guardian _____ Date _____