2018-19 EMERGENCY INFORMATION

_____ _____

Name of Student Grade

TREATMENT AUTHORIZATION

(I)(We), the undersigned parent(s) of _____ (a minor), do hereby authorize the representatives of New Vista School of Laguna Hills as agent(s) for the undersigned to consent to any x-ray examination, anesthetic, medical, or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician and surgeon licensed under the provisions of the Medicine Practice Act on the medical staff of any accredited hospital, whether such diagnosis or treatment is rendered at the office of such physician or at such hospital. It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment, or hospital care which the aforementioned physician in the exercise of his/her best judgment may deem advisable.

Please list any medication(s) the student currently takes at <u>home</u>:

Name	Dose	Frequency	Reason

Medication(s) the student will take <u>during school hours</u>: (Please fill out NVS Prescription Medication Authorization form for each medication)

Name	Dose	Frequency	Reason

☐ Check here if student does not have any scheduled medications at school.

HEALTH HISTORY
List any health diagnosis, conditions, vision, hearing, medical allergies, or physical restrictions:

_____

_____

_____

_____

_____

DIETARY RESTRICTIONS: (Please Specify)

☐ Gluten-Free

☐ Dairy Free

☐ List other food allergies: _____

_____

_____

IMMUNIZATION:
Date of Tdap: _____ Date of Last Tetanus: _____
Date of Personal Believe Exemption: _____ Date of Medical Exemption: _____
(please provide a copy of the PBE or ME for the school)

PHYSICIAN/INSURANCE INFORMATION:
Student's
Physician_____City_____Telephone_____

Name of Health Insurance Company _____

Policy/Group/Member Numbers _____

Preferred Hospital _____City_____

My student, _____ has permission to travel to field trips and other school-sponsored activities under the supervision of responsible adults. I assume reasonable safety precautions will be taken, and understand that I am responsible for health insurance coverage.

Parent/Guardian Signature _____ Date Signed _____