DELAWARE EMERGENCY TREATMENT CARD

Student Name: _____ **Birth Date:** _____
Last First

Grade/Teacher: _____ Gender: ( ) Male ( ) Female

Resides with: ( ) Mother ( ) Father ( ) Other: _____

Mother/Guardian Information

Name		Home Phone	Date of Birth
Street Address			
City	Zip	Development	
Place of Employment		Email	
Business Phone	Ext.	Cell Phone	Pager

Father/Guardian Information

Name		Home Phone	Date of Birth
Street Address			
City	Zip	Development	
Place of Employment		Email	
Business Phone	Ext.	Cell Phone	Pager

If parents/guardians cannot be reached, call:

1. _____ _____ _____ _____
Name Relationship Daytime Phone Home Phone

2. _____ _____ _____ _____
Name Relationship Daytime Phone Home Phone

Indicate student's serious medical problems and any medicines taken routinely: _____

Student is allergic to: Food, Medicine or Other (Be Specific—Name of food, medicine, etc): _____

Medical Insurance: _____

I give permission for my child to have Potassium Iodide if authorized by Delaware Emergency Management Agency Officials.

Please check ☐ Yes ☐ No

Please sign & date Parent/Guardian _____
Sign Date

I give permission for my child to have Tylenol (Acetaminophen), Advil (Ibuprofen) or an antacid (Tums) as determined by the nurse.

Please check ☐ Yes ☐ No

I verify that all of the above information is correct. This information may be shared with school personnel on a "need to know" basis.

Please sign & date Parent/Guardian _____
Sign Date

SCHOOL EMERGENCY PROCEDURES

Your school has adopted the following procedures that will normally be followed in caring for your child when he/she becomes sick or injured at school. In extreme emergencies the school will seek immediate medical care. In case of emergency and/or need of medical or hospital care:
1. The school will call the home. If there is no answer, 2. The school will call the father's, mother's, or guardians place of employment. If there is no answer, 3. The school will call the other telephone number(s) listed and the physician. 4. If none of the above answer, the school will call an ambulance, If necessary, to transport the student to a local medical facility. 5. Based upon the medical judgment of the attending physician, the student may be admitted to a local medical facility. 6. The school will continue to call the parents, guardians or physician until one is reached.
If I cannot be reached and the school authorities have followed the procedures described, I agree to assume all expenses for moving and medically treating this student. I also hereby consent to any treatment, surgery, diagnostic procedures or the administration of aesthesis which may be carried out based on the medical judgment of the attending physician.

Please sign & date Parent/Guardian Signature _____
Sign Date

STUDENT HEALTH HISTORY UPDATE

This information will be shared on a need to know basis with staff, administration and emergency medical staff in the case of an emergency unless you notify us otherwise.

*Date*_____ *Parent/Guardian's Signature*_____

*Student*_____ *DOB:*_____ *Grade*_____ *Teacher*_____

PLEASE CHECK IF CHILD HAS HAD DIFFICULTY WITH ANY OF THE FOLLOWING. GIVE DATES AND ADDITIONAL INFORMATION UNDER COMMENTS.

1. [ ] ADD/ADHD [ ] Allergies [ ] Asthma [ ] Blood Disorder [ ] Body Piercing/Tattoo [ ] Bone/Spine [ ] Bowel/Bladder [ ] Diabetes [ ] Emotional [ ] Hearing [ ] Heart [ ] Infections [ ] Kidney [ ] Physical Disability [ ] Seizures [ ] Speech [ ] Surgery [ ] Vision

   [ ] OTHER_____

   Comments:_____

   _____

2. Does your child have allergies to medicine, food, latex or insect bites?

   NO [ ] YES [ ] To What_____ What happens?_____

   Treatment_____

3. Has your child had any illnesses since school last ended?

   NO [ ] YES [ ] Type of illness, with date(s)_____

4. Has your child had surgery since school last ended?

   NO [ ] YES [ ] Type of surgery, with date(s)_____

5. Has your child received any immunizations since school last ended?

   NO [ ] YES [ ] List immunizations, with dates_____

6. Is your child being treated or evaluated for any health conditions?

   NO [ ] YES [ ] List condition_____

7. Is your child on any medication or treatment?

   NO [ ] YES [ ] Name of medication and/or treatment_____

   Does your child need medicine during school hours?

   NO [ ] YES [ ] ***If yes, please contact the school nurse to make arrangements.***

8. Has your child ever been examined by an eye doctor?

   NO [ ] YES [ ] Date of last exam_____

   NO [ ] YES [ ] Glasses Prescribed

   If your child wears glasses or contact lenses, when was the prescription last changed_____

9. What is the name of your child's dentist? _____

   What is the date of his/her last dental exam? _____

10. What is the name of your child's primary healthcare provider? _____

    What is the date of his/her last physical exam? _____

11. Has your child experienced any major life events, such as a recent move, death, separation, divorce, etc. since the end of last school year?

    NO [ ] YES [ ] ***If yes, please contact your School Nurse or School Counselor.***

12. Have you, your child or anyone in your household tested positive for COVID-19?

    NO [ ] *YES* [ ] ***If yes, please contact the school nurse.***

Revised 7/17/2020