2025/2026 INDIAN RIVER SCHOOL DISTRICT- DELAWARE EMERGENCY TREATMENT CARD

GRADE: _____ ID#_____

TEACHER:_____

LAST NAME: _____ FIRST NAME: _____ DATE OF BIRTH:____/____/____

PARENT/GUARDIAN INFORMATION:

Name:		Name:	
Relationship:		Relationship:	
Date of Birth:		Date of Birth:	
Driver's License ID		Driver's License ID	
Home Street Address		Home Street Address	
City, State, Zip		City, State, Zip	
Alert Now Number:		Alert Now Number:	
Home/Cell Number:		Home/Cell Number:	
Place of Employment:		Place of Employment:	
Work Phone #	Ext.	Work Phone #	Ext.
E-Mail Address:		E-Mail Address:	
Custody Situation: (Must have custody papers)			
******PLEASE NOTIFY THE SCHOOL IF YOUR PHONE NUMBER OR CONTACT INFORMATION CHANGES DURING THE YEAR*****			

Name/School of other children living in household: _____

IF PARENTS CANNOT BE REACHED, CALL:

1._____

NAME RELATIONSHIP TO STUDENT PHONE CELL PHONE

2._____

NAME RELATIONSHIP TO STUDENT PHONE CELL PHONE

MEDICAL INSURANCE: ( ) Yes ( ) No Type:_____ MEDICAID ( ) Yes ( )No Type: _____

Number:_____ Number:_____

School Nurses can give non-prescription and prescription medications with written parental/guardian permission. See the below process:

1. The school nurse must assess the child's complaint and symptoms to determine if other measures can be used before medication.
2. All medications must be brought to school by parent or adult designee. Medications cannot be sent to school on the bus and must be in the original container/package (DE Law). They may not be kept with the student during school hours, with the exception of an annual/completed "permission to carry form".
3. The school nurse will keep a record of the medication given to your child.

Please check yes or no below for the medications your child is allowed to have during school hours.

( )YES ( )NO Acetaminophen/Tylenol (pain/fever) ( )YES ( )NO Ibuprofen/Motrin/Advil (pain/fever)

( )YES ( )NO Antacid (stomach upset) ( )YES ( )NO **cough drops**/Chloraseptic spray (Sore throat relief)

( )YES ( )NO Anbesol/Orajel (mouth pain) List allergies to any medications:_____

**NOTE: Nurses use antiseptic wash, antibiotic ointment, anti-itch cream/lotion, hydrocortisone cream & eye wash for routine first aid care.

If you do not want these treatments used on your child, please make the nurse aware.

SCHOOL EMERGENCY PROCEDURES

Your schools have adopted the following procedures in caring for a student when he/she becomes sick or injured at school:

In case of a life-threatening emergency, the school will call 911 and then follow the steps below. In case of other emergencies 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 guardian's 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 anesthesia which may be carried out based on the medical judgment of the attending physician. **HOSPITAL PREFERENCE**:_____

I have read and understand the information on **BOTH SIDES** of this form and I understand that this information will be shared with staff and administration on a need to know basis unless you notify us otherwise.

PARENT/GUARDIAN SIGNATURE_____ DATE_____

PLEASE TURN OVER AND COMPLETE OTHER SIDE

2025/2026 INDIAN RIVER SCHOOL DISTRICT- 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 [ ] Bone/Spine [ ] Heart [ ] Speech [ ]
   Allergies [ ] Bowel/Bladder [ ] Infections [ ] Surgery [ ]
   Asthma [ ] Diabetes [ ] Kidney [ ] Vision [ ]
   Blood Disorder [ ] Emotional [ ] Physical Disability
   [ ] Body Piercing/Tattoo [ ] Hearing [ ] Seizures [ ]
   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 ended in June?
   NO [ ] YES [ ] Type of illness, with date(s)_____
4. Has your child had surgery since school ended June?
   NO [ ] YES [ ] Type of surgery, with date(s)_____
5. Has your child received any immunizations since school ended in June?
   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. Has your child had any emotional upsets (recent move, death, separation, divorce) since school ended in June?
   NO [ ] YES [ ] List_____
10. What is the name of your child's dentist?
    _____
    What is the date of his/her last dental exam? _____
11. What is the name of your child's primary healthcare provider? _____
    What is the date of his/her last physical exam? _____

IMPORTANT REMINDERS

*If your child has a medical condition requiring medication, treatment, or specialized care, please contact the school nurse.

*If your child is missing any requirement for attending a public school in Delaware, he/she may be excluded from school (Physical, Lead, TB, Immunizations).

*Screenings: (Screenings per Delaware guidelines)-GRADES: K,2,4,7,9 or 10 & new enterers will have vision and hearing screening. GRADES: 5-9 will have scoliosis screening. (A letter will be sent home with your child if a follow-up with his/her physician is needed).

Please contact the nurse's office with any questions or concerns.

*****THANK YOU FOR TAKING THE TIME TO COMPLETE THIS FORM*****