

2025-2026 CAPE HENLOPEN SCHOOL DISTRICT- DELAWARE EMERGENCY TREATMENT CARD

STUDENT'S LAST NAME: _____ FIRST NAME: _____ DATE OF BIRTH: ____/____/____

PARENT/GUARDIAN INFORMATION: Resides with: _____ Relationship: _____

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
Home Number:	Home Number:
Cell Number:	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)	Preferred Language:
*****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.

I give permission for my child to have the following checked medication during school hours (generic medication may be substituted for named brand).
Please check off the medications the school nurse may administer to your child during school hours.

() Acetaminophen/Tylenol (pain/fever) () Ibuprofen/Advil (pain/fever)
 () Antacid (stomach upset) () Cough Drops
 () Anbesol/Orajel (mouth pain) (() Chloraseptic spray (sore throat relief)
) Benadryl (allergies)
 () Loratadine (generic for Claritin) **List allergies to any medications:**

****NOTE: Nurses use antiseptic wash, antibiotic ointment, calamine lotion, and hydrocortisone for routine first aid care.
 If you do not want these treatments used on your child, please make the nurse aware.**

The purpose of this form is to provide the school with information to be used for the care a student who becomes sick or injured at school. This information may be shared only on a "need to know" basis with school personnel and emergency medical staff. Parental permission is given for the school nurse to obtain needed medical information from the student's primary care physician.

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 an emergency and/or need of medical or hospital care, the school will call EMS (911) for transport to the nearest medical facility.

1. The school will contact the parents utilizing all numbers available listed on the emergency card.
2. The school will call the other telephone number(s) listed.
3. Based upon the medical judgment of the attending physician, the student may be admitted to a local medical facility.
4. The school will continue to call the parents or guardians 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.

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 CAPE HENLOPEN 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 [] Body Piercing/Tattoo [] Emotional [] Kidney [] Surgery
[] Allergies [] Bone/Spine [] Hearing [] Physical Disability [] Vision
[] Asthma [] Bowel/Bladder [] Heart [] Seizures [] Other: _____
[] Blood Disorder [] Diabetes [] Infections [] Speech _____

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 in June
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 had any emotional upsets (recent moves, death, separation, divorce, anxiety, depression, behavior problems, sleep patterns) since the end of last school year?
NO [] YES [] *If yes, please contact your School Nurse or School Counselor

ADDITIONAL ITEMS / REMINDERS

- All medications must be brought into the nurse & cannot be kept with the student during school hours, unless your child has a signed "Permission to Carry" form on file. Permission to Carry forms must be completed each year.
• Students in grades 5-9 will have Postural and Gait (scoliosis) screening.
• Students in grades K,2,4,7,9 or 10 & new enterers will have vision and hearing screening. (Per Delaware guidelines).
• Students in Kindergarten will have a dental screening (Per Delaware guidelines).

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS FORM (Rev.8/18/25)

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