DATE:_____ CAPE HENLOPEN SCHOOL DISTRICT- DE 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)			
********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)
( ) Antacid (stomach upset)
( ) Anbesol/Orajel (mouth pain)
( ) Benadryl (allergies)
( ) Loratadine (generic for Claritin)
( ) Ibuprofen/Advil (pain/fever)
( ) Cough Drops
( ) Chloraseptic spray (sore throat relief)

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

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 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. 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?_____

ADDITIONAL ITEMS / REMINDERS

- Do you have any concerns regarding the following in regards to your child (circle any related issues)?
  Anxiety / Depression / Sleep patterns / Behavior changes
- 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)

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

Revised 5/2026

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