

# MILFORD SCHOOL DISTRICT

## DELAWARE EMERGENCY TREATMENT CARD

Please complete and return: The State of Delaware requires all students to have an emergency card on file in the School Nurse's Office.

|               |                |              |         |
|---------------|----------------|--------------|---------|
| Student Name: | DOB:    /    / | School Year: | School: |
|---------------|----------------|--------------|---------|

### PARENT/GUARDIAN INFORMATION:

|                                                                                 |                     |
|---------------------------------------------------------------------------------|---------------------|
| Name:                                                                           | Name:               |
| Relationship:                                                                   | Relationship:       |
| Date of Birth:                                                                  | Date of Birth:      |
| Address:                                                                        | Address:            |
| City, State, Zip                                                                | City, State, Zip    |
| Home/Cell Number                                                                | Home/Cell Number    |
| Place of Employment                                                             | Place of Employment |
| Work Phone #                                                                    | Work Phone #        |
| E-Mail Address:                                                                 | E-Mail Address:     |
| Custody Situation: (Must have custody papers)                                   |                     |
| ***PLEASE NOTIFY THE SCHOOL IF YOUR PHONE NUMBER OR CONTACT INFORMATION CHANGES |                     |

### IF PARENTS CANNOT BE REACHED, CALL:

|    |      |                         |       |            |
|----|------|-------------------------|-------|------------|
| 1. |      |                         |       |            |
|    | NAME | RELATIONSHIP TO STUDENT | PHONE | CELL PHONE |
| 2. |      |                         |       |            |
|    | NAME | RELATIONSHIP TO STUDENT | PHONE | CELL PHONE |

### SCHOOL EMERGENCY PROCEDURES

Your schools have 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 Mother's, Father's or Guardian's place of employment. If there is no answer,
3. The school will call the other telephone number(s) listed and/or the physician.
4. If none of the above answers, 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.**

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

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### MEDICATION PERMISSION

School Nurses can give non-prescription and prescription medications with written parent/guardian permission. The following process will be followed: 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 sent to school **MUST BE IN THE ORIGINAL CONTAINER/PACKAGE**. This is the Law. 3) The school nurse will keep a record of the medication given to your child.

### Please Check below for the medications your child may have during the school day:

- |                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                 |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Ibuprofen/Advil<br><input type="checkbox"/> Eye Wash<br><input type="checkbox"/> Anbesol/Orajel (Dental Pain)<br><input type="checkbox"/> Hygiene Supplies<br><input type="checkbox"/> Anti-Fungal Cream<br><input type="checkbox"/> Lip Ointment<br><input type="checkbox"/> Benadryl<br><input type="checkbox"/> Skin Ointments | <input type="checkbox"/> Anti-Itch Lotion<br><input type="checkbox"/> Sting Kill<br><input type="checkbox"/> Burn Spray<br><input type="checkbox"/> Throat Spray<br><input type="checkbox"/> Calamine Lotion<br><input type="checkbox"/> Antacid/Tums<br><input type="checkbox"/> Cough Drops<br><input type="checkbox"/> Acetaminophen/Tylenol |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

List Medication Allergies Below:

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Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## STUDENT HEALTH HISTORY UPDATE

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

|               |                |              |         |
|---------------|----------------|--------------|---------|
| Student Name: | DOB:    /    / | School Year: | School: |
|---------------|----------------|--------------|---------|

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 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.***

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_