(Front and back please) **DELAWARE EMERGENCY TREATMENT DATA CARD**

Student's Last Name_____ First Name_____ MI_____
Birth Date_____ School _____ Grade_____ Teacher _____Bus No_____

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

_____ What Happens: _____ Treatment: _____

Indicate student's **serious medical conditions**: _____

Regular Medications: _____

Home Address_____ Home Phone_____
Resides with_____Relationship_____

Mother/Guardian's Name_____	Father/Guardian's Name_____
Cell #_____	Cell #_____
Mother's/Guardian's Place of Employment _____	Father's/Guardian's Place of Employment _____
Phone_____ Ext._____	Phone_____ Ext._____
EMAIL: _____	EMAIL: _____

If parents/guardians cannot be reached please call:

Name _____Relationship_____ **Cell #**_____Alternate #_____
Name _____Relationship_____ **Cell #**_____Alternate #_____

Family Doctor: _____Phone: _____ **Dentist:** _____ Phone: _____

Date of most recent physical exam: _____ Date of most recent dental check-up: _____

Eye Doctor: Date of last exam_____ Glasses Prescribed? _____ Date prescription last changed? _____

Medical Insurance: _____ Other:_____
No Insurance: _____ **(BCBS, Aetna, etc.) (Certificate No. Group No.)**

***I give permission for my child's Doctor, School Nurse and Medical Facilities to discuss my child's health information.**
***I give permission for my child to have the following medication according to the medication label**. The nurse will refrain from medication until basic care tried (ex. Ginger ale/crackers/rest for upset stomach)

_____yes _____no Orajel/Anbesol	**_____yes _____no First Aid Antiseptic Burn cream**
_____yes _____ no Tylenol (acetaminophen)	**_____yes _____no Antacids (ex. Tums or Pepto-Bismol)**
_____yes _____ no Advil/Motrin (ibuprofen)	**_____yes _____no Benadryl (Diphenhydramine)**
_____yes _____ no Cough drops	**_____yes _____no Hydrocortisone cream/ointment (itch)**
_____yes _____ no Caladryl Clear (itch)	**_____yes _____no Bactine Spray to clean "boo-boos"**

Parent/Guardian Signature _____ Date_____

I verify the above information is correct. This information may be shared only on a "need to know" basis with school personnel and emergency medical staff.

SCHOOL EMERGENCY PROCEDURES

The 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 the school will call EMS (911) for transport to the nearest medical facility:**

1. The school will contact the Parents/Guardians utilizing available listed on the emergency card.
2. The school will call the other telephone number(s) listed.
3. Based upon the medical judgement 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.
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. By signing this form, I acknowledge understanding the purpose of the form and attest to the accuracy of the information.

Parent/Guardian Signature _____ Date _____

STUDENT HEALTH HISTORY UPDATE

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

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 the us otherwise.

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** **[ ] Physical Disability**
   [ ] Allergies **[ ] Bone/Spine** **[ ] Hearing** **[ ] Seizures**
   [ ] Asthma **[ ] Bowel/Bladder** **[ ] Heart** **[ ] Speech**
   [ ] Autism
   [ ] Behavior **[ ] Chicken Pox** **[ ] Infections** **[ ] Surgery**
   [ ] Bleeding **[ ] Diabetes** **[ ] Kidney** **[ ] Vision**

[ ] OTHER_____

2. **Has your child had any illnesses since school ended in June?**
   Type of illness, with date(s) _____
3. **Has your child had surgery since school ended in June?**
   Type of surgery, with date(s) _____
4. **Has your child received any immunizations since school ended in June?**
   List immunizations, with dates: _____
5. **Has your child had any emotional upsets (recent move, death, separation, divorce) since school ended in June?** List: _____

If your child has an allergy requiring Benadryl_____ and/or an Epi-Pen_____:

1) ***When was the child's last exposure?*** _____
2) ***How severe are the reactions?*** _____
3) ***Have they ever had to go to the Emergency Room because of the allergy?*** _____
4) ***Have they ever spent overnight in a Hospital because of the allergy?*** _____

Please be aware the permission forms for prescription and non-prescription medications are in the Nurse's office (302-292-1463 ext. 208) and the website. **The medication must be in the original packaging or pharmacy labeled container (with child's name and prescribing Doctor on the label. All medication must be within proper use dates (not expired).** Medication must be brought in by and sent home with a parent or guardian over 18 years of age (with the exception of self-carry asthma inhalers and Epi-pens where the parents and MD have signed a form and the form is on file with the Nurse)

***Please provide an updated Action Plan from the Medical Doctor** **your child sees to assist the Nurse's actions for your child with CHRONIC CONDITIONS:** Please give the Nurse any care plan, protocols, and/or emergency care plan. Children with life-threatening conditions must have an emergency care plan in place. (Epi-pen users, Cardiac, Asthma, Diabetes, Seizures, etc.)

Parent/Guardian's Signature: _____Date: _____