Thomas Edison Charter School

DELAWARE EMERGENCY/NURSING TREATMENT CARD
2020/2021

LAST NAME: ________________FIRST NAME: ___________________DATE OF BIRTH: ___/___/___

School Name: ______________________________Homeroom or Teacher: _____________________________

PARENT/GUARDIAN INFORMATION	
Name: ___________________________________	Name: ___________________________________
Relationship: ______________________________	Relationship: ______________________________
Home Address: _____________________________	Home Address: _____________________________
Home Phone: ______________________________	Home Phone: ______________________________
Cell Phone: ________________________________	Cell Phone: ________________________________
Place of Employment:__________________________	Place of Employment:__________________________
Work Phone: ____________________Ext.: _____	Work Phone: ____________________Ext.: _____

If PARENTS/GUARDIANS CANNOT BE REACHED, CALL:

1. ____
Name   Address   Phone
2. ____
Name   Address   Phone

Physician: __________________ Phone:_________ Family Dentist: ___________ Phone: ________________________

Indicate student's serious medical diagnoses: ____

Student is allergic to: Medicine: ____________________ Food: _______________________ Other: ___________________

Medical Insurance: Medicaid No.________________________ Other:_____________________________________
Certificate No.   Group No.   Type

The purpose of this form is to provide the school with information to be used for the care of 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.

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SCHOOL PROCEDURES

Your 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/guardian utilizing all numbers available listed on this 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 transporting 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

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
   [ ] Allergies
   [ ] Asthma
   [ ] Blood Disorder
   [ ] Body Piercing/Tattoo
   [ ] Bone/Spine
   [ ] Bowel/Bladder
   [ ] Diabetes
   [ ] Emotional
   [ ] Hearing
   [ ] Heart
   [ ] Infections
   [ ] Kidney
   [ ] Physical Disability
   [ ] Seizures
   [ ] Speech
   [ ] Surgery
   [ ] Vision
   [ ] 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.***

12. Have you, your child or anyone in your household tested positive for COVID-19?

    NO [ ] YES [ ] ***If yes, please contact the school nurse.***

Revised 7/17/2020