Emergency Treatment Card

Student Name:______________________________________ Grade:_________ Birth date: _________

CHECK ABOVE INFORMATION FOR ACCURACY. CROSS OUT AND CORRECT ANY INCORRECT INFORMATION

Resides with: ________________________________ Relationship: ________________________________

Mother/Guardian Information

Name: ______________________________________

Home Phone: ____________ Date of Birth: ____________

Home Address: ________________________________

____

Social Security Number: __________________________

Place of Employment: ____________________________

Business Phone: ________________ Ext: ___________

Cell Phone: ________________ Pager: _____________

E-Mail Address: _______________________________

Stepfather Name: ________________________

Place of Employment: ____________________________

Business Phone: ________________ Ext: ___________

Father/Guardian Information

Name: ______________________________________

Home Phone: ____________ Date of Birth: ____________

Home Address: ________________________________

____

Social Security Number: __________________________

Place of Employment: ____________________________

Business Phone: ________________ Ext: ___________

Cell Phone: ________________ Pager: _____________

E-Mail Address: _______________________________

Stepmother Name: ________________________

Place of Employment: ____________________________

Business Phone: ________________ Ext: ___________

If parents/guardians cannot be reached, Emergency contacts are:

1. ____
   Name Relationship Daytime Phone Alt Phone

2. ____
   Name Relationship Daytime Phone Alt Phone

3. ____
   Name Relationship Daytime Phone Alt Phone

Family Physician: ____________________________________ Phone: ________________________

Family Dentist: ____________________________________ Phone: ________________________

Student's serious medical problems and any medicines taken routinely: ________________________________

____

Student Allergies: Food, Medicine or Other (Be Specific – Name of food, medicine, etc.): ________________________

____

Health Insurance Provider ______________ Policy # ____________________ ID#______________________

SCHOOL EMERGENCY PROCEDURES

Your school has adopted the following procedure 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 make calls in the following order until an adult is spoken with:

1. Home, cell phone, place of employment, and then emergency contacts. If no answer,
2. The school will call the physician. If no answer,
3. The school will call an ambulance, if necessary, to transport the student to a local medical facility, wherein the medical professional will make further decisions in the best interest of the child.
4. The school will continue to call the parents, guardians or emergency contact until one is reached.
5. The information on this form may be shared with emergency medical staff.

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.

Parent/Guardian Signature ____ Date ____________________

This Emergency Card and the Signature are considered up-to-date, valid, and will remain in effect until the student graduates, withdraws, or unless a written request is made by the parent/ caretaker/guardian to void the information or consent expressed in the completion of this form by signature and date.

Please complete reverse side of this form as well

STUDENT HEALTH HISTORY UPDATE

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

Date: ___________________ Parent/Guardian's Signature: ____

Student: _________________________________ DOB: _________________ Grade: ___________________

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 Problem	[ ] Hearing	[ ] Seizures
[ ] Asthma	[ ] Bowel/Bladder	[ ] Heart	[ ] Speech
[ ] Behavior	[ ] Chicken Pox	[ ] Infections	[ ] Surgery
[ ] Bleeding	[ ] Diabetes	[ ] Kidney	[ ] Vision

[ ] Other ____

Comments: ____

____

2. Is your child on any medication or treatment?

   NO [ ] YES [ ] Name of medication and/or treatment ____

3. Does your child need medicine during school hours?

   NO [ ] YES [ ] ***If yes, please contact the school office to make arrangements.***

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

   NO [ ] YES [ ] To What ____________________ What happens _________________________________

   Treatment ____

5. Has your child had any illnesses since school ended in June?

   NO [ ] YES [ ] Type of illness, with date(s) ____

6. Has your child had surgery since school ended in June?

   NO [ ] YES [ ] Type of surgery, with date(s) ____

7. Has your child received any immunizations since school ended in June?

   NO [ ] YES [ ] List immunizations, with date(s) ____

8. Is your child being treated or evaluated for any health conditions?

   NO [ ] YES [ ] List condition ____

9. Has your child ever been examined by an eye doctor?

   NO [ ] YES [ ] Date if last exam _______________ Glasses Prescribed NO [ ] YES [ ]

   If your child wears glasses or contact lenses, when was the prescription last changed ___________________________

10. Has your child had any emotional upsets (recent move, death separation, divorce) since school ended in June?

    NO [ ] YES [ ] List ____

11. What is the date of his/her last dental exam? ____

12. What is the date of his/her last physical exam? ____

<u>Non-Prescription Medication Authorization***</u>***

1.) I authorize CCA to administer the following non-prescription medications [please select all that apply]:
___ibuprofen ____acetaminophen ____antacid ____ benadryl, per the instructions on the label, to my child.

2.) I ___would ____would not* like a phone every time my child requests the above selected medicines while at school or under the care of school personnel.
**** Parents of students in 6th grade and below will receive a call each time medication is requested unless there is a doctor's order and prescription.***

____ ___________________________
Parent Signature ***Date***