



DELAWARE EMERGENCY/NURSING TREATMENT CARD
2020/2021 School Year

LAST NAME: _____ FIRST NAME: _____ DATE OF BIRTH: _____

School Name: _____ Grade _____

| 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.

SCHOOL PRODEDURES

Your school has adopted the following procedures that will normally be followed in caring for your student 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 _____