School Year:_____

DELAWARE EMERGENCY/NURSING TREATMENT CARD

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_____