Odyssey Charter School
Nurturing a Lifelong Love of Learning

2018-2019

DELAWARE EMERGENCY TREATMENT CARD
STUDENT INFORMATION

_____ _____
(LAST NAME) **(FIRST NAME)** **(MI)** **(BIRTH DATE)**

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Grade: _____ **Homeroom #:** _____ **Teacher:** _____ **Male:** _____ **Female:** _____

Before/After School Care Provider: _____ **Phone:** _____

CHILD RESIDES WITH: _____ **RELATIONSHIP:** _____

MOTHER/GUARDIAN INFORMATION	FATHER/GUARDIAN INFORMATION
Name_____DOB:_____	Name_____DOB:_____
Home Phone_____	Home Phone_____
Home Address_____	Home Address_____
_____	_____
Place of Employment_____	Place of Employment_____
Work Phone_____Ext_____	Work Phone_____Ext_____
Cell Phone_____	Cell Phone_____
STEPFATHER/SPOUSE INFORMATION	**STEPMOTHER/SPOUSE INFORMATION**
Name_____DOB:_____	Name_____DOB:_____
Home Phone_____	Home Phone_____
Home Address_____	Home Address_____
_____	_____
Place of Employment_____	Place of Employment_____
Work Phone_____Ext_____	Work Phone_____Ext_____
Cell Phone_____	Cell Phone_____

IF PARENTS/GUARDIANS CANNOT BE REACHED, LIST TWO CONTACTS IN THE LOCAL AREA TO CALL:

1. _____
(Name) (Relation to Student) (Home Phone) (Cell Phone) (Work Phone)

2. _____
(Name) (Relation to Student) (Home Phone) (Cell Phone) (Work Phone)

Does your child have allergies to? (Please Circle)

Bee Sting/Insect Bites	**YES**	**NO**	Type: _____	Reaction: _____	Treatment: _____
Food	**YES**	**NO**	Type: _____	Reaction: _____	Treatment: _____
Medication	**YES**	**NO**	Type: _____	Reaction: _____	Treatment: _____
Other	**YES**	**NO**	Type:_____	Reaction: _____	Treatment: _____

If you have marked "yes" to any of the above, please specify in the comments on side two.

I give permission for my child to be given Benadryl for bee sting/food/medication/latex/insect bite allergy: YES _____ NO _____

I give permission for my child to be given acetaminophen (Tylenol) as determined by the nurse: YES _____ NO _____

I give permission for my child to be given Ibuprofen (Advil/Motrin) as determined by the nurse: YES _____ NO _____

I give permission for my child to be given TUMS as determined by the nurse: YES _____ NO _____

I give permission for my child to be given Cough Drops as determined by the nurse: YES _____ NO _____

I give permission for my child to be transport by school staff if medically necessary: YES _____ NO _____

The School Nurse is authorized to decline to administer any medication.
I verify that all of the above information is correct.
This information may be shared with school personnel on a "Need to Know" basis.

_____ _____
Parent Signature Date

SEE SIDE TWO →

STUDENT HEALTH HISTORY UPDATE

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

[ ] Other/ Special Dietary Requests:_____

Comments: _____

2. Has your child had any illness or surgery since school ended in June? [ ] NO [ ] YES

If yes, list type of Illness with date(s) _____

3. Has your child received any immunizations since school ended in June? [ ] NO [ ] YES

If yes, please send in updated immunization record.

4. Is your child being treated or evaluated for any health conditions? [ ] NO [ ] YES

If yes, list type of condition _____

5. Is your child on any medication or treatment? [ ] NO [ ] YES

If yes, list the mediation and/or treatment _____
Does your child require medication during school hours? [ ] NO [ ] YES
If YES, please contact school nurse to make arrangements.

6. Has your child ever been examined by an eye doctor? [ ] NO [ ] YES

If yes, list date of last exam _____ Were glasses/contact lenses prescribed? [ ] NO [ ] YES

7. Has your child had any recent emotional upsets (move, death, separation)? [ ] NO [ ] YES

If yes, list type _____

8. Name of your child's dentist? _____ Phone: _____ Date of last exam? _____

9. Name of your child's doctor? _____ Phone: _____ Date of last exam? _____

10. Is this your child's first experience in a Delaware Public School? [ ] NO [ ] YES

If yes, previous school/years attended:_____

SCHOOL EMERGENCY PROCEDURES

Your schools have 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:

1. The school will call the home. If there is no answer,
2. The school will call the father', mother's or guardian's place of employment. If there is no answer,
3. The school will call the other telephone number(s) listed and the physician.
4. If none of the above answer, the school will call an ambulance, if necessary, to transport the student to a local medical facility.
5. Based upon the medical judgment of the attending physician, the student may be admitted to a local medical facility.
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 procedure, or the administration of anesthesia, which may be carried out based on the medical judgment of the attending physician.

I verify that all of the above information is correct.
I understand that the above information will be shared with staff and administration on a need to know basis, and with emergency medical staff in the case of emergency, unless I notify you otherwise.

Parent/Guardian Signature: _____ **Date:** _____

Please return to your child's teacher by:
Tuesday, September 11, 2018