2025-2026

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:** ______________

PLEASE SPECIFY IF CUSTODY IS SHARED:____

*** PARENT/GUARDIAN #1 INFORMATION***	*** PARENT/GUARDIAN #2 INFORMATION***
Name________________________DOB:________	Name________________________DOB:________
Relationship to student: ____________________	Relationship to student: ____________________
Home Phone____________________________	Home Phone____________________________
Home Address__________________________	Home Address__________________________
______________________________________	______________________________________
Place of Employment____________________	Place of Employment____________________
Work Phone______________________Ext______	Work Phone______________________Ext______
Cell Phone_____________________________	Cell Phone_____________________________
STEP-PARENT INFORMATION	STEP-PARENT INFORMATION
Name________________________DOB:________	Name________________________DOB:________
Work Phone______________________Ext______	Work Phone______________________Ext______
Cell Phone_____________________________	Cell Phone_____________________________

IF PARENTS/GUARDIANS CANNOT BE REACHED, LIST 2-3 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)

3. ____
(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: __________

Does your child have Food restrictions/special dietary requests not listed above? (List below)

____

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 have the following over the counter medications administered by the nurse (check all that apply):

First Aid Cream___ Caladryl (for itch)____ Antibiotic Ointment___ Hydrocortisone___ Bee Sting Swabs___ Burn Spray___ Tums___

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/GUARDIAN SIGNATURE Date

SEE SIDE TWO

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: ____

If your child has seizures, diabetes, asthma or food allergies, please give school nurse all medications, including emergency medications and Emergency Action Plans updated this year.

2. Please list all of your child's allergies to medicine, food, latex, insect bites:____

What happens: ____________________________________Treatment:____

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

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

4. Has your child had surgery since school has been out? [ ] NO [ ] YES Date:__________ Surgery: __________________

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

If yes, list type of condition ____

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

Please list all mediations and/or treatments ____

Does your child require medication/treatments during school hours? [ ] NO [ ] YES ****If YES, please contact school nurse.**

7. 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

8. Has your child had any recent emotional upsets that require additional support? (move, death, separation, divorce etc.)? [ ] NO [ ] YES

*If yes explain ____

9. Name of your child's dentist: ______________________________ Phone: __________________ Date of last exam? ___________

10. Name of your child's doctor: ______________________________ Phone: __________________ Date of last exam? ____________

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.

Medical Information					
Medical Insurance:				Type:	
Certificate No:		Group No:		Medicaid No:	

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____________