Student Health Emergency Card

School Year: ____2018-2019______________________________ **Grade:**______________________

Student: ___________________________ /___________________________ ______ /_______/_____ MALE ☐ FEMALE ☐

(LAST NAME) (FIRST NAME) (DATE OF BIRTH)

EMERGENCY CONTACT INFORMATION

Parent/Guardian:

________________________________/_________________/____________________/____________________/____________________
Name Relationship Work Phone Home Phone Cell Phone

________________________________/_________________/____________________/____________________/____________________
Name Relationship Work Phone Home Phone Cell Phone

Please list below three people who have your permission to pick your child up from school and make decisions concerning your child in the event that you cannot be reached.

Name of Person **Relationship** **Telephone**

1.______________________________________/________________________________/______________________________________

2.______________________________________/________________________________/______________________________________

3.______________________________________/________________________________/______________________________________

Insurance Name _____________________________________ Insurance #___________________________

Doctor____ Doctor's Phone #_________________________

Dentist______________________________ Hospital Preference___________________________________

Every School is required to have first responders trained in CPR and First Aid. In the event of an emergency, the school staff will contact 911 and follow their instructions. Every attempt will be made to contact a parent, guardian, or designated emergency contact.

I give the school nurse permission to exchange information with my child's healthcare provider. All information will be kept strictly confidential and used only to provide appropriate individualized healthcare services for my child while in school or school related event.

Parent/Guardian Signature____ Date:___________________________________

Medication/Medical Procedures:

Any medication or medical procedure (blood sugar check, tube feeding) to be administered at school or school related activities, requires a Doctors Order Form to be completed. Medication must be provided by the parent in the original, sealed, properly labeled container. Doctors Order forms are available from the school nurse.

Last Name____________________________________ **First Name**____________________________________

Please address each yes or no question. All Information below is confidential for the school nurse:

Consent for Treatment/Release of Information	□ **YES** □ **NO**	I consent for High Point Academy to provide nursing services to my child; release and exchange health and personal identification information to Medicaid for billing purposes (if applicable) which will remain confidential and will NOT affect any services my child receives.
Over the Counter Medications	□ **YES** □ **NO**	□ **Tylenol** □ **Ibuprofen** □ **Antibiotic Ointment** □ **Hydrocortisone Cream** □ **Benadryl** □ **Caladryl** □ **Tums**
ADD/ADHD	□ **YES** □ **NO**	☐Takes Medication at Home ☐ Needs Medication at School ADD/ADHD Doctor's name:________________________________Phone______________________
Allergies	□ **YES** □ **NO**	☐ Seasonal ☐ Severe (Life Threatening) ☐ Takes Medication at Home ☐ Needs Medication at School ☐ Emergency Medication (EpiPen/Benadryl) Last date EpiPen Used ______/______/______ Allergy Doctor's name:____
Asthma	□ **YES** □ **NO**	☐ Daily Maintenance Medication ☐ Rescue Inhaler ☐ Rescue Nebulizer Asthma Doctor's name:______________________________Phone___________________________
Diabetes	□ **YES** □ **NO**	☐ Type 1 ☐ Type 2 ☐ Blood Glucose Checks ☐ Oral Medication ☐ Carb Counting ☐ Takes Insulin ☐Shots ☐Pump ☐Glucagon Diabetes Doctors Name:____________________________________
Epilepsy (Seizures)	□ **YES** □ **NO**	☐ Daily Medication ☐ Diastat ☐ Other Needs/Treatments ☐ Date of Last Seizure______/______/______ Seizure Doctor's name:____ Phone___________________________
Mental Health Consideration	□ **YES** □ **NO**	Type ____________________________________ ☐ Takes Medication At Home ☐ Needs Medication at School Mental Health Providers name:____ Phone________________________
Sickle Cell Anemia	□ **YES** □ **NO**	☐ Trait ☐ Disease ☐ Takes Medication at Home ☐ Needs Medication at School ☐ Last Hospitalization ______/_____/______ Sickle Cell Doctor's name:______________________________________
Physical Limitation	□ **YES** □ **NO**	Type ____ ☐ Limitations ☐ Assistive Device Required ☐Takes Medication at Home ☐Needs Medication at school Disability Doctor:__________________________________
Hearing Considerations	□ **YES** □ **NO**	☐ Hearing Aids ☐ Cochlear Implant ☐ Other
Vision Considerations	□ **YES** □ **NO**	☐ Glasses ☐ Contacts ☐ Other
Feeding Considerations	□ **YES** □ **NO**	☐ Swallowing ☐ G-tube feeding at school
Elimination Considerations	□ **YES** □ **NO**	☐ Diapering ☐ Catherization at school
Other	□ **YES** □ **NO**	Describe:

Parent / Guardian

Signature____**Date**_______________________________