Revised 04/2013

DOUGLAS COUNTY SCHOOL SYSTEM
School Emergency Health Information Card

SCHOOL _____ **GRADE**_____ **SCHOOL YEAR**_____

STUDENT _____ **M or F**_____ **DOB**_____ **TEACHER** _____

ADDRESS _____

Type of Health Care Insurance: ____ Medicaid ____ Peachcare ____ Other / Private_____
Dental Insurance _____ yes _____ no Vision Insurance _____ yes _____ no

Medical conditions for which student is being treated by a medical provider include: (Please circle)

Diabetes Asthma Sickle Cell Disease Cancer Seizures Hydrocephalus with Shunt

List other medical conditions currently being treated by a medical provider: (*Please include any implantable medical devices such as a defibrillator, pacemaker, cochlear implants or vagal nerve stimulator*) _____

_____

- *Medical conditions requiring special medical treatment and/or staff training, other than standard first aid, will require written physician guidelines. Please provide the written physician guidelines to your school's health monitor who will forward the guidelines to your school's Registered Nurse (RN).*

List current medications prescribed by physician:_____

_____

- *If student has been prescribed an emergency medication (Epi-Pen, Diastat, inhaler, etc.) parent/guardian must provide the emergency medication to the school along with permission forms.*

List known student allergies:_____

_____

- *If student requires a special diet at school, you will be provided a form for your physician to complete. Completed forms should be returned to the cafeteria manager.*

Student's Physician_____ **Phone** _____

Student's Dentist_____ **Phone** _____

EMERGENCY CONTACT INFORMATION

Mother /Guardian_____ **Phone (Home)** _____ **Mobile** _____
Phone (Work) _____

Father /Guardian_____ **Phone (Home)** _____ **Mobile** _____
Phone (Work) _____

If parents/guardians cannot be reached, list two nearby persons who will assume care of student.

Name _____ **Relationship** _____ **Phone** _____

Name _____ **Relationship** _____ **Phone** _____

AUTHORIZATION FOR EMERGENCY TREATMENT

In case of serious illness/injury, the school will telephone Emergency Medical Services (911) for assessment and immediate transportation to the closest appropriate hospital. I, the parent/legal guardian, authorize the transport of and treatment by the hospital emergency staff for my child, _____. Fees for transportation and medical services will be the responsibility of the parent/guardian.

Parent/Guardian Signature _____ **Date**_____

Parent/Guardian Email _____ _____