Revised 01/2009

DOUGLAS COUNTY SCHOOL SYSTEM
School Emergency Health Information Card

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

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

ADDRESS _____

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

STUDENT HEALTH HISTORY (PLEASE CHECK ALL THAT APPLY AND PLEASE UNDERLINE THOSE CURRENTLY UNDER TREATMENT OR DOCTOR'S CARE)

☐ ASTHMA	☐ SEIZURES/EPILEPSY	☐ CYSTIC FIBROSIS	☐ ADD/ADHD
☐ HEART PROBLEMS	☐ KIDNEY PROBLEMS	☐ BLEEDING TENDENCIES	☐ DEPRESSION
☐ SICKLE CELL DISEASE	☐ STOMACH PROBLEMS	☐ FREQUENT NOSE BLEEDS	☐ OTHER BEHAVIOR PROBS
☐ HEADACHES	☐ SKIN DISORDERS	☐ DIABETES	LIST_____
☐ COCHLEAR IMPLANTS	☐ VISION PROBLEMS	☐ DEAFNESS	☐ IMPAIRED MOBILITY

☐ **OTHER CURRENT MEDICAL PROBLEMS**_____

IF YOUR CHILD HAS ANY MEDICAL CONDITION REQUIRING SPECIAL MEDICAL TREATMENT(other than standard first aid) AND STAFF TRAINING, PLEASE PROVIDE WRITTEN PHYSICIAN GUIDELINES TO THE SCHOOL HEALTH MONITOR.

Please list surgeries or hospitalizations _____
Please list ALL medications student routinely takes and times _____ _____
_____

Student's Healthcare Provider_____ **Phone** _____

Student's Dentist_____ **Phone** _____

ALLERGIES
Is student allergic to any medication? _____ **Please list**_____
Does student have any food allergies? _____ **Please list** _____
Does student have any other allergies? _____ **Please list** _____
Has student had an allergic reaction to any bee/insect stings? If yes, what type of reaction occurs? _____
_____
Does he/she have an Epi-pen /Twin ject in case of emergency at school? (must be provided by parent/guardian) Yes ___ **No** _____

EMERGENCY CONTACT INFORMATION

Mother /Guardian_____ **Phone (Home)**_____ **Pager** _____
Phone (work)_____ **Cellular**_____
Father /Guardian_____ **Phone (Home)**_____ **Pager** _____
Phone (work)_____ **Cellular**_____

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

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

NON-EMERGENCY TREATMENT/FIRST AID (AS DESCRIBED IN SCHOOL HEALTH RESOURCE MANUAL)
Provide treatment needed: (Please circle) Yes No
Wait for approval before treatment by: _____ **Parent** _____**Emergency Contact**

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 emails _____ _____