CAESAR RODNEY SCHOOL DISTRICT-MEDICAL CARD

Student Name: _____ Birth Date: _____ Age: _____
Last First MI

Grade:_____ Teacher:_____ Room: _____ Male _____ Female _____

Resides with: ☐Mother ☐ Father ☐ Other: _____ Custody papers on file, if applicable

Mother/Guardian Name	Date of Birth	*Father/Guardian Name*	Date of Birth
Street Address or P.O. Box	Development	Street Address or P.O. Box	Development
City & Zip Code	Home Phone ( )	City & Zip Code	Home Phone ( )
Employer Name	Work Phone ( )	Employer Name	Work Phone ( )
Employer Department	Work Extension	Employer Department	Work Extension
Mother/Guardian-Email Address	Cell Phone ( )	Father/Guardian-Email Address	Cell Phone ( )

If parents/guardians cannot be reached, call: (Local contact preferred.)

1. _____ _____ _____ _____ _____
Name Relationship to student Cell Phone Home Phone Work Phone

2. _____ _____ _____ _____ _____
Name Relationship to student Cell Phone Home Phone Work Phone

Names of siblings living with student Grade Age

_____

_____

Please check

Medical Insurance: ☐Yes ☐No If yes: ☐Private ☐Medicaid – Delaware physician's care
☐Medicaid – United Medicaid Number: _____

I give permission for my child to have the age and weight appropriate dose of Tylenol (*Acetaminophen*), Advil (*Ibuprofen*) or an antacid as determined by and at the discretion of the nurse.

Please check _____ ☐Yes ☐No

I verify that all of the above information is correct.
This information may be shared with school personnel on a "need to know" basis.

Please sign & date Parent/Guardian Signature _____ Date _____

SCHOOL EMERGENCY PROCEDURES/ATTENDANCE REQUIREMENTS

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 contact the parents utilizing all numbers available listed on the emergency card.
2. The school will call the other telephone number(s) listed.
3. If none of the above answer, the school will call EMS (911) for transport to the nearest medical facility.
4. Based upon the medical judgment of the attending physician, the student may be admitted to a local medical facility.
5. The school will continue to call the parents or guardians 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 procedures or the administration of anesthesia which may be carried out based on the medical judgment of the attending physician.

Mandatory Attendance Requirements-Sect.2702, Chapter 27, Title 14, Del Code

I agree to make every reasonable effort to (1) have my child abide by the school code of conduct; (2) make certain that my child attends school regularly; and (3) to provide written documentation for the reason(s) for any absence.

Please sign & date Parent/Guardian Signature _____ Date _____

PLEASE COMPLETE REVERSE SIDE

STUDENT HEALTH HISTORY UPDATE

This information will be shared on a need to know basis with staff, administration and emergency medical staff in the case of an emergency unless you notify us otherwise.

*Date*_____ *Parent/Guardian's Signature*_____

*Student*_____ *DOB:*_____ *Grade*_____ *Teacher*_____

PLEASE CHECK IF CHILD HAS HAD DIFFICULTY WITH ANY OF THE FOLLOWING. GIVE DATES AND ADDITIONAL INFORMATION UNDER COMMENTS.

1. [ ] ADD/ADHD [ ] Bone/Spine [ ] Heart [ ] Speech
   [ ] Allergies [ ] Bowel/Bladder [ ] Infections [ ] Surgery
   [ ] Asthma [ ] Diabetes [ ] Kidney [ ] Vision
   [ ] Blood Disorder [ ] Emotional [ ] Physical Disability
   [ ] Body Piercing/Tattoo [ ] Hearing [ ] Seizures
   [ ] OTHER_____
   Comments:_____
   _____
2. Does your child have allergies to medicine, food, latex or insect bites?
   NO [ ] YES [ ] To What_____ What happens_____
   Treatment_____
3. Has your child had any illnesses since school ended in June?
   NO [ ] YES [ ] Type of illness, with date(s)_____
4. Has your child had surgery since school ended in June?
   NO [ ] YES [ ] Type of surgery, with date(s)_____
5. Has your child received any immunizations since school ended in June?
   NO [ ] YES [ ] List immunizations, with dates_____
6. Is your child being treated or evaluated for any health conditions?
   NO [ ] YES [ ] List condition_____
7. Is your child on any medication or treatment?
   NO [ ] YES [ ] Name of medication and/or treatment_____
   Does your child need medicine during school hours?
   NO [ ] YES [ ] ****If yes, please contact the school nurse to make arrangements.***
8. Has your child ever been examined by an eye doctor?
   NO [ ] YES [ ] Date of last exam_____
   NO [ ] YES [ ] Glasses Prescribed
   If your child wears glasses or contact lenses, when was the prescription last changed_____
9. Has your child had any emotional upsets (recent move, death, separation, divorce) since school ended in June?
   NO [ ] YES [ ] List_____
10. What is the name of your child's dentist? _____
    What is the date of his/her last dental exam? _____
11. What is the name of your child's primary healthcare provider? _____
    What is the date of his/her last physical exam? _____

Thank you.

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