

DOUGLAS COUNTY SCHOOL SYSTEM  
School Emergency Health Information Card

Revised 01/2009

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)**

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> ASTHMA              | <input type="checkbox"/> SEIZURES/EPILEPSY | <input type="checkbox"/> CYSTIC FIBROSIS      | <input type="checkbox"/> ADD/ADHD             |
| <input type="checkbox"/> HEART PROBLEMS      | <input type="checkbox"/> KIDNEY PROBLEMS   | <input type="checkbox"/> BLEEDING TENDENCIES  | <input type="checkbox"/> DEPRESSION           |
| <input type="checkbox"/> SICKLE CELL DISEASE | <input type="checkbox"/> STOMACH PROBLEMS  | <input type="checkbox"/> FREQUENT NOSE BLEEDS | <input type="checkbox"/> OTHER BEHAVIOR PROBS |
| <input type="checkbox"/> HEADACHES           | <input type="checkbox"/> SKIN DISORDERS    | <input type="checkbox"/> DIABETES             | LIST _____                                    |
| <input type="checkbox"/> COCHLEAR IMPLANTS   | <input type="checkbox"/> VISION PROBLEMS   | <input type="checkbox"/> DEAFNESS             | <input type="checkbox"/> 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 \_\_\_\_\_