

Emergency Card

School Year

Student: _____ / _____ / _____ / _____ MALE FEMALE
(LAST NAME) (FIRST NAME) (DATE OF BIRTH)(GRADE/SECTION)

EMERGENCY CONTACT INFORMATION

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Parent/Guardian:

_____/_____/_____/_____/_____
Name Relationship Work Phone Home Phone Cell Phone

_____/_____/_____/_____
Street Address City Zip e-mail

_____/_____/_____
Mailing Address (if different from Street Address) City Zip

Parent/Guardian (if different from above):

_____/_____/_____/_____/_____
Name Relationship Work Phone Home Phone Cell Phone

_____/_____/_____/_____
Street Address City Zip e-mail

_____/_____/_____
Mailing Address (if different from Street Address) City Zip

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.

<u>Name of Person</u>	<u>Relationship</u>	<u>Telephone</u>
1. _____	_____/_____	_____/_____
2. _____	_____/_____	_____/_____
3. _____	_____/_____	_____/_____

Every school has a nurse assigned to them and first responders trained in CPR and First Aid. The nurse may not be on the school campus at all times. 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 a designated emergency contact.

Hospital Choice _____

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.

Parent / Guardian Signature: _____ **Date:** _____

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Medication/Medical Procedures: (CCSD policy JLCD-Assisting Students with Medications)

Please note that the CCSD schools are no longer allowed to stock over the counter medications. Any medication to be administered at school requires a Doctors Order form to be completed by the parent and the doctor. Medication must be provided by the parent in the original, sealed, properly labeled container. Any medical procedure (such as blood sugar checks, tube feedings) to be performed at school requires a Doctors Order form to be completed by the parent and the doctor. Doctors Order forms are available from the school nurse or online at:

http://www.ccsdschools.com/Departments_Staff_Directory/Academic_Division/HealthServices/

Screenings:

CCSD school nurses follow DHEC recommendations for vision, hearing, blood pressure, BMI, and dental screenings as time permits. Contact your school nurse if you do not want your child to participate. Head Start and Early Head Start nurses follow program requirements for vision, hearing, blood pressure, height/weight, dental, lead and developmental screenings.

Please complete the information below for your child.

Consent	<input type="checkbox"/> YES <input type="checkbox"/> NO	I give permission for the school nurse to release information to Medicaid, if applicable, which will remain confidential and will NOT affect any services my child receives.
ADD/ADHD	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Takes Medication at Home <input type="checkbox"/> Needs Medication at School ADD/ADHD Doctor's name: _____
Allergy	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Environmental/Seasonal <input type="checkbox"/> Severe (Life Threatening) <input type="checkbox"/> Takes Medication at Home <input type="checkbox"/> Needs Medication at School <input type="checkbox"/> Emergency Medication (EpiPen/Benadryl) Last date EpiPen used ____/____/____ Allergy Doctor's name: _____
Asthma	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Daily Maintenance Medication <input type="checkbox"/> Rescue Inhaler <input type="checkbox"/> Rescue Nebulizer Asthma Doctor's name: _____
Diabetes	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> Blood Glucose Checks <input type="checkbox"/> Oral Medication <input type="checkbox"/> Carb Counting <input type="checkbox"/> Takes Insulin <input type="checkbox"/> Shots <input type="checkbox"/> Pump <input type="checkbox"/> Glucagon Diabetes Doctors Name: _____
Seizure Disorder	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Daily Medication <input type="checkbox"/> Diastat <input type="checkbox"/> Other Needs/Treatments <input type="checkbox"/> Date of Last Seizure ____/____/____ Seizure Doctor's name: _____
Psychiatric Disorder	<input type="checkbox"/> YES <input type="checkbox"/> NO	Type _____ <input type="checkbox"/> Takes Medication At Home <input type="checkbox"/> Needs Medication at School Mental Health Providers name: _____
Sickle Cell Anemia	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Trait <input type="checkbox"/> Disease <input type="checkbox"/> Takes Medication at Home <input type="checkbox"/> Needs Medication at School <input type="checkbox"/> Last Hospitalization ____/____/____ Sickle Cell Doctor's name: _____
Physical Disability	<input type="checkbox"/> YES <input type="checkbox"/> NO	Type _____ <input type="checkbox"/> Limitations <input type="checkbox"/> Assistive Device Required <input type="checkbox"/> Takes Medication at Home <input type="checkbox"/> Needs Medication at school Disability Doctor's name: _____
Hearing Considerations	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Hearing Aids <input type="checkbox"/> Cochlear Implant <input type="checkbox"/> Other
Vision Considerations	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Other
Feeding Considerations	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Swallowing <input type="checkbox"/> G-tube feeding at school
Elimination Considerations	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Diapering <input type="checkbox"/> Catheterization at school
Other	<input type="checkbox"/> YES <input type="checkbox"/> NO	Describe: _____

Parent / Guardian Signature _____ **Date** _____