Emergency Card

School Year

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

EMERGENCY CONTACT INFORMATION

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.

Name of Person	Relationship	Telephone
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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Student: _____ /_____ /_____/_____ ☐ MALE ☐ FEMALE
(LAST NAME) (FIRST NAME) (DATE OF BIRTH)(GRADE/SECTION)

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	☐**YES** ☐**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	☐**YES** ☐**NO**	☐Takes Medication at Home ☐Needs Medication at School ADD/ADHD Doctor's name:
Allergy	☐**YES** ☐**NO**	☐Environmental/Seasonal ☐Severe (Life Threatening) ☐ Takes Medication at Home ☐Needs Medication at School ☐Emergency Medication (EpiPen/Benadryl) Last date EpiPen used ____/___/____ Allergy Doctor's name:
Asthma	☐**YES** ☐**NO**	☐Daily Maintenance Medication ☐Rescue Inhaler ☐Rescue Nebulizer Asthma Doctor's name:
Diabetes	☐**YES** ☐**NO**	☐Type 1 ☐Type 2 ☐Blood Glucose Checks ☐Oral Medication ☐Carb Counting ☐Takes Insulin ☐Shots ☐Pump ☐Glucagon Diabetes Doctors Name:
Seizure Disorder	☐**YES** ☐**NO**	☐Daily Medication ☐Diastat ☐Other Needs/Treatments ☐Date of Last Seizure___/____/____ Seizure Doctor's name:
Psychiatric Disorder	☐**YES** ☐**NO**	Type _____☐Takes Medication At Home ☐Needs Medication at School Mental Health Providers name:
Sickle Cell Anemia	☐**YES** ☐**NO**	☐Trait ☐Disease ☐Takes Medication at Home ☐Needs Medication at School ☐Last Hospitalization _____/____/_____ Sickle Cell Doctor's name:
Physical Disability	☐**YES** ☐**NO**	Type _____ ☐Limitations ☐Assistive Device Required ☐Takes Medication at Home ☐Needs Medication at school Disability Doctor's name:
Hearing Considerations	☐**YES** ☐**NO**	☐Hearing Aids ☐Cochlear Implant ☐Other
Vision Considerations	☐**YES** ☐**NO**	☐Glasses ☐Contacts ☐Other
Feeding Considerations	☐**YES** ☐**NO**	☐Swallowing ☐G-tube feeding at school
Elimination Considerations	☐**YES** ☐**NO**	☐Diapering ☐Catheterization at school
Other	☐**YES** ☐**NO**	Describe:

Parent / Guardian Signature_____**Date**_____