DCIU
Empowering Partnerships For Education

Emergency Information Card

DELAWARE COUNTY DCTS TECHNICAL HIGH SCHOOLS

School Year ______________________ **School Name** ______________________

Student Demographic Information					
Name:			Gender: ❐ Male ❐ Female		
Address:			DOB:	Age:	Grade
City:	State:	Zip:	Home District:		
Siblings & Ages:			Program Name:		
			Student Lives With:		
			Primary Language Spoken at Home:		

Parent/Guardian Information (2 Contacts)					
Name:			Name:		
Address:			Address:		
City:	State:	Zip:	City:	State:	Zip:
Relationship to Student:			Relationship to Student:		
Home Phone:	Cell Phone:		Home Phone:	Cell Phone:	
Work Phone:	Email:		Work Phone:	Email:	

Emergency Contact (2 Contacts)			
Primary Contact:		Secondary Contact:	
Relationship to Student:		Relationship to Student:	
Home Phone:	Cell:	Home Phone:	Cell:
Work Phone:	Email:	Work Phone:	Email:

Medical Information	
Primary Physician Name:	Primary Physician Phone:
Preferred Hospital:	
Allergies/Reactions: ❐ Medicine ____________ ❐ Food ____________ ❐ Seasonal ____________ ❐ No Known Allergies ❐ Other ______________	
Date of Last Tetanus Shot:	
Is the Student Subject to: Seizures ❐ Yes ❐ No Date of Last Seizure?____________ ❐ Asthma ❐ ADHD ❐ Sensitive to Medication ____________________ ____________________ ❐ Cardiac Condition ❐ Diabetes (1 or 2) ❐ Hemophilia ❐ Hearing Problem ❐ Eyesight Problem ❐ Cerebral Palsy ❐ Arthritis/ Rheumatic Disease ❐ Anxiety/Depression ❐ Other __________________ __________________________	

Please note: *A student's attendance in a Pennsylvania and DCIU program is conditional on the receipt of documentation that the student has met the required immunizations for the child's age.*

I hereby give permission for ________________________________ to be taken to a hospital or doctor in case of an emergency.

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Signature of Parent/Guardian Date

Turn Over To Complete →

Medications

Over the Counter Authorization
The below treatments may be administered at the discretion of the school nurse according to symptoms present, in accordance with a student's individual medication plan if present.

Yes	No		Yes	No		Yes	No		Yes	No	
❐	❐	Acetaminophen (Tylenol)	❐	❐	Eucerin or Aquafor	❐	❐	Balmex	❐	❐	Aloe
❐	❐	Ibuprophen (Advil/Motrin)	❐	❐	Tums	❐	❐	Cough Drops/Lozenges	❐	❐	Contact Lens solution, refresh eye drops, wetting solutions
❐	❐	Benadryl	❐	❐	Antibiotic Ointments	❐	❐	Anbesol or Oragel			
❐	❐	Calagel	❐	❐	Sterile Eye Wash	❐	❐	Salt Water Gargles			

Medications to be taken during school hours:

Medication Name	Dosage	Time	Delivery ❐ Oral ❐ Rectal ❐ IV ❐ G Tube
Medication Name	Dosage	Time	Delivery ❐ Oral ❐ Rectal ❐ IV ❐ G Tube
Medication Name	Dosage	Time	Delivery ❐ Oral ❐ Rectal ❐ IV ❐ G Tube

Medications given at home:

Medication Name	Dosage	Time	Delivery ❐ Oral ❐ Rectal ❐ IV ❐ G Tube
Medication Name	Dosage	Time	Delivery ❐ Oral ❐ Rectal ❐ IV ❐ G Tube
Medication Name	Dosage	Time	Delivery ❐ Oral ❐ Rectal ❐ IV ❐ G Tube

Consent

I hereby give permission for ______________________________________ to be administered the above medication(s). The listed medical treatments above may be administered at the discretion of the school nurse according to symptoms present, in accordance with a student's individual medication plan if present.

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Signature of Parent/Guardian Date