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.*

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 Aquaphor			Balmex			Aloe
		Ibuprofen (Advil/Motrin)			Tums			Cough drops/lozenges			Contact Lens /wetting solutions
		Benadryl			Antibiotic Ointments			Anbesol or Oragel			Eye drops
		Calagel			Sterile Eye Wash			Saltwater Gargles			

Medications to be taken during school hours:

Name:	Dosage:	Time:	Route:			
			☐ Oral	☐ Rectal	☐ IV	☐ G Tube
			☐ Oral	☐ Rectal	☐ IV	☐ G Tube
			☐ Oral	☐ Rectal	☐ IV	☐ G Tube

Medications given at home:

Name:	Dosage:	Time:	Route:			
			☐ Oral	☐ Rectal	☐ IV	☐ G Tube
			☐ Oral	☐ Rectal	☐ IV	☐ G Tube
			☐ Oral	☐ Rectal	☐ IV	☐ G Tube

Consent

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

Signature of Parent/Guardian Date

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. All prescription medications to be taken during school hours require prior authorization and accompanying signed medical order.

Signature of Parent/Guardian Date