EMERGENCY Health Form

Sussex Technical High School **School Year: _______**

LAST NAME: ______________________________ FIRST NAME: ______________________ DATE OF BIRTH: ___/___/___

Gender: Male/Female GRADE: _________ (Upper Classmen) Technical Pathway: __________________________

PARENT/GUARDIAN INFORMATION	
Name/Relation: ____________________	Name/Relation: ____________________
Email: ____________________	Email: ____________________
Home Address: ____________________ ____________________	Home Address: ____________________ ____________________
Home/Cell Phone: ____________________	Home/Cell Phone: ____________________
Place of Employment: ____________________	Place of Employment: ____________________
Work Phone: ______________ Ext.: ______	Work Phone: ______________ Ext.: ______

If PARENTS/GUARDIANS CANNOT BE REACHED, CALL:

1. Name/Relation: ______________________ Phone #: ______________ Phone #: ______________
2. Name/Relation: ______________________ Phone #: ______________ Phone #: ______________
3. Name/Relation: ______________________ Phone #: ______________ Phone #: ______________

Primary Care Provider: ________________________________ Phone # ________________

Family Dentist: ________________________________ Phone #: ________________

Medical Insurance Provider: ________________________ Policy #: ________________________

The purpose of this form is to provide the school with information to be used for the care of a student who becomes sick or injured at school. This information may be shared only on a "need to know" basis with school personnel and emergency medical staff.

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SCHOOL PROCEDURES

Sussex Technical High School has adopted the following procedures that will normally be followed in caring for your child when he/she becomes sick or injured at school. In extreme emergencies the school will seek immediate medical care.

In case of emergency and/or need of medical or hospital care the school will call EMS (911) for transport to the nearest medical facility:

1. The school will contact the parents/guardian utilizing all numbers available listed on this emergency card.
2. The school will call the other telephone number(s) listed.
3. Based upon the medical judgment of the attending physician, the student may be admitted to a local medical facility.
4. The school will continue to call the parents or guardians until one is reached.

If I cannot be reached and the school authorities have followed the procedures described, I agree to assume all expenses for transporting and medically treating this student. I also hereby consent to any treatment, surgery, diagnostic procedures or the administration of anesthesia which may be carried out based on the medical judgment of the attending physician.

By signing this form, I acknowledge understanding the purpose of the form and attest to the accuracy of the information.

****Parent/Guardian Signature: ______________________________ Date: ____________________**

Over-the-Counter Medications

I give permission for the school nurse to give my child non-prescription medications such as: (acetaminophen, ibuprofen, antacids, diphenhydramine, loratadine, topical creams, etc.)

****Parent/Guardian Signature: ______________________________ Date: ____________________**

Student Health History Update (*This information will be shared on a need to know basis with staff, administration, and emergency medical staff in the case of an emergency unless you notify us otherwise.)*

Last Name: ______________________ First Name: ______________________ Date of Birth: ___/___/_____

Gender: Male/Female   Grade: _________   (Upper Classmen) Technical Area: ______________________

PLEASE CHECK IF CHILD HAS HAD DIFFICULTY WITH ANY OF THE FOLLOWING. GIVE DATES AND ADDITIONAL INFORMATION UNDER COMMENTS.

1) [ ] ADD/ADHD
[ ] Allergies
[ ] Asthma
[ ] Blood Disorder
[ ] Body Piercing/Tattoo
[ ] Bone/Spine
[ ] Bowel/Bladder
[ ] Diabetes
[ ] Emotional
[ ] Hearing
[ ]Heart
[ ] Infections
[ ] Kidney
[ ] Physical Disability
[ ] Seizures
[ ] Speech
[ ] Surgery
[ ] Vision

Other:______________________

Comments:______________________

2) Does your child have **Allergies** to **Medicine, Food, Latex, Insect bites/stings, or Environmental Factors**?

[ ] NO [ ] YES To What:______________________

What Happens? ______________________

Treatment: ______________________

****Any child prescribed an EPIPEN will need an Emergency Action Plan, Medication Consent, & Epipen in School****

3) Has your child had any illnesses since school last ended?

[ ] NO [ ] Yes Type of Illness, with date(s): ______________________

4) Has your child had any surgery since school last ended?

[ ] NO [ ] YES Type of Surgery, with date(s):______________________

5) Has your child received any immunizations since school last ended?

[ ] NO [ ] YES List immunizations, with dates:______________________

6) Is your child being treated or evaluated for any health conditions?

[ ] NO [ ] YES List Condition:______________________

7) Is your child on any medication or treatment?

[ ] NO [ ] YES Name of medication and/or treatment: ______________________

Does your child need medicine during school hours? **If yes**, call 302-854-2819 or Nurses@sussexvt.k12.de.us

[ ] NO [ ] YES **If yes**, see Nurse Office tab on Website for Consent Forms & Action Plans (Allergy, Asthma, Seizure)

8) Has your child ever been examined by an eye doctor? Date of Last Exam: ______________________

[ ] NO [ ] YES, If **yes**, were glasses prescribed [ ] NO [ ] YES

9) What is the date of his/her last dental exam? ______________________

10) What is the date of his/her last physical exam? ______________________

11) Indicate student's Serious Medical Diagnoses: ______________________

12) Has your child experienced any major life events, such as a recent move, death, separation, divorce, etc. since school last ended?

[ ] NO [ ] YES ** If **yes**, please contact school nurse or school counselor to seek counseling resources in-school.

*****Parent/Guardian's Signature:**______________________ Date: __________