Early College High School Emergency/Nursing Treatment Card

Student Name: ______________________________ □Male □Female Grade: _____

DOB: ________ Advisory Teacher: ________________ Last School Attended: ________________

Student Physical Address
____
Number Street City State Zip

Parent/Guardian Information	
Mother/Guardian 1 Information	Father/Guardian 2 Information
Mother/Guardian 1 Name: ______________________	Father/Guardian 1 Name: ______________________
Home Phone: ______________________	Home Phone: ______________________
Work Phone: ______________________	Work Phone: ______________________
Cell Phone: ______________________	Cell Phone: ______________________
Email Address: ______________________	Email Address: ______________________
Student Resides with this parent/guardian: □ Yes □ No	Student Resides with this parent/guardian: □ Yes □ No

Emergency Contacts	
In case of an emergency, the following people may act on my/our behalf to treat and/or pick-up my child in the event he/she is sick: (State requires 2 local contacts and they cannot be parents listed above)	
Name: ______________________	Name: ______________________
Address: ______________________	Address: ______________________
Home Phone: ______________________	Home Phone: ______________________
Work Phone: ______________________	Work Phone: ______________________
Cell Phone: ______________________	Cell Phone: ______________________
Relationship: ______________________	Relationship: ______________________

Medical Information	
Allergies: ______________________	Medication Taken: ______________________
Does your child have Asthma? □ Yes □ No	Does your child use a rescue inhaler? □ Yes □ No
Does your child use an EpiPen? □ Yes □ No	Medical History: ______________________
Medical Insurance Carrier: ______________________	Group Number: ______________________
Family Doctor: ______________________	Phone: ______________________
Dentist: ______________________	Phone: ______________________

Parental Permissions

In an emergency, all contacts will be used. If we are unsuccessful in reaching a parent or contact, my signature below indicates that I agree to have my child transported to the closest medical facility. I also give permission for emergency personnel to perform emergency treatment on my child, including emergency surgery if indicated, in the event I cannot be reached. I release the school of all liability related to the emergency transport and emergency care provided by the hospital and transport team.

My signature below also indicates that I give permission for my child to receive over the counter (OTC) medications such as Motrin, Tylenol, Topical Ointments, Cough Drops, etc. during the school day at the discretion of the school nurse. NO COLD OR SEASONAL ALLERGY medications are provided.

Parental Signature Section

______________________________ ______________________

Parent/Guardian Signature Date

Additional People Who May Pick Up My Child	
Name: ______________________	Relationship: ______________________
Name: ______________________	Relationship: ______________________
Name: ______________________	Relationsihp: ______________________