Red Clay Consolidated School District

STUDENT DATA CARD

School Year: 2022-2023			
For Office Use Only:			
School:			
ID:			
Grade:		***Hmrm:***	

STUDENT INFORMATION

First Name:				2022-2023 Grade:	
Middle Name:				Birth Date:	
Last Name:				Nickname/Preferred Name:	
Generation:	☐ Jr. ☐ Sr. ☐ II ☐ III ☐ IV ☐ V	Gender:	☐ Male ☐ Female	Primary Phone:	

RACE and ETHNICITY DESIGNATION

Is this student Hispanic or Latino? (Select one answer.) Persons of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race, are considered Hispanic or Latino ☐ Yes ☐ No

Indicate this student's race below. You must select at least one race, regardless of ethnicity designation. More than one response may be selected.

☐ American Indian or Alaskan Native American ☐ Black or African American ☐ White ☐ Asian ☐ Native Hawaiian or Pacific Islander

ADDRESS Please indicate Physical (home) and Mailing address if they are different.

Physical Address		Mailing Address Same as Physical? ☐ Yes ☐ No	
Apt #:		Apt #:	
Address:		Address:	
Development:		Development:	
City, State, Zip:		City, State, Zip:	

SPECIAL CUSTODY INFORMATION If child lives with anyone other than mother or father listed on birth certificate please indicate:

Name:	
Relationship:	
Custodial Papers on file with school?:	☐ Yes ☐ No

ADDITIONAL INFORMATION

Has the student been expelled? ☐ Yes ☐ No

Does your child have (documentation required):

IEP (Individualized Education Plan)? ☐ Yes ☐ No	Learning Difficulties ☐ Yes ☐ No
504 Accommodation Plan? ☐ Yes ☐ No	Physical Difficulties: ☐ Yes ☐ No

EDUCATION BACKGROUND INFORMATION Name and address of previous school, pre-school, or day care

Name:			
Address:			
City, State, Zip:			
Phone:		Fax:	

SCHOOL AGE SIBLING INFORMATION

Name:				Name:			
School:		Grade:		School:		Grade:	
Name:				Name:			
School:		Grade:		School:		Grade:	

For Office Use Only:	Student:		ID:	

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.

1. Please check if child has had difficulty with any of the following. Please provide dates and additional information in the comments section.

☐ ADD/ADHD	☐ Bleeding/Blood Disorder	☐ Concussion	☐ Heart	☐ Seizures
☐ Allergies	☐ Body Piercing/Tattoo	☐ Diabetes	☐ Infections	☐ Speech
☐ Asthma	☐ Bone/Spine	☐ Emotional	☐ Kidney	☐ Surgery
☐ Behavior	☐ Bowel/Bladder	☐ Hearing	☐ Physical Disability	☐ Vision

☐ Other: _____

Comments: _____

( ) Yes ( ) No **2. Does your child have allergies to medicine, latex or insect bites?**

To What? _____ What Happens? _____

Treatment _____

( ) Yes ( ) No **3. Does your child have a food allergy?**

To What? _____ What Happens? _____

Treatment _____

A Food Allergy Action Plan completed by a licensed healthcare provider is required for all students with a food allergy. Please provide an Emergency Action Plan and ALL emergency medications to the School Nurse.

( ) Yes ( ) No **4. Will your child require an individualized, allergen-free menu designed by Nutrition Services?**

Note: Meals provided from home provide the safest food options at school for food-allergic students.

☐ **No.** I will take full responsibility for providing my child with allergen-free school meals.

☐ **Yes.** I will provide the School Nurse with a Food Allergy Plan completed by a licensed healthcare provider.

( ) Yes ( ) No **5. Has your child had any illnesses since school last ended?**

Type of illness, with date(s): _____

( ) Yes ( ) No **6. Has your child had surgery since school last ended?**

Type of surgery, with date(s): _____

( ) Yes ( ) No **7. Has your child received any immunizations since school last ended?**

List of immunization(s), with date(s): _____

( ) Yes ( ) No **8. Is your child being treated or evaluated for any health conditions?**

List condition(s): _____

( ) Yes ( ) No **9. Is your child on any medication or treatment?**

Name of medication and/or treatment: _____

( ) Yes ( ) No Does your child need medicine during school hours? ***If yes, please contact the School Nurse to make arrangements.***

( ) Yes ( ) No **10. Has your child ever been examined by an eye doctor?**

Date of last _____ Glasses Prescribed: **( ) Yes ( ) No**

If your child wears glasses or contact lenses, when was the prescription last changed? _____

( ) Yes ( ) No **11. What is the name of your child's dentist?** _____

What is the date of his/her last dental exam? _____

12. What is the name of your child's primary healthcare provider? _____

What is the date of his/her last physical exam? _____

( ) Yes ( ) No **13. Has your child experienced any major life events, such as a recent move, death, separation, divorce, etc. since the end of last school year? *If yes, please contact your School Nurse or School Counselor.**

( ) Yes ( ) No **14. Have you, your child or anyone in your household tested positive for COVID-19? *If yes, please contact the School Nurse.***

Parent/Guardian Signature: _____ **Date:** _____

Permission for Over the Counter Medication Administration

I give permission for my child to have the following; as determined by the nurse:

Acetaminophen (Tylenol®) ☐ Yes ☐ No Ibuprofen (Advil®) ☐ Yes ☐ No Tums® ☐ Yes ☐ No

Parent/Guardian Signature: _____ **Date:** _____

For Office Use Only:	Student:		ID:	

DELAWARE EMERGENCY/NURSING TREATMENT CARD

Medical Information

Physician: _____ Phone: _____

Family Dentist: _____ Phone: _____

Indicate student's serious medical diagnoses: _____

Student is allergic to: Medicine: _____ Food: _____ Other: _____

Medical Insurance: Medicaid No.: _____

Other: Certificate No.: _____ Group No.: _____ Type: _____

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.

SCHOOL EMERGENCY PROCEDURES

Your schools have adopted the following procedures that will normally be followed in caring for your child when your child requires emergency assistance at school for either a medical or behavioral health concern. In extreme emergencies the school will seek immediate medical care.

In case of emergency and/or need of medical or hospital care:

1. The school will call the home. If there is no answer,
2. The school will call the parent/guardian 1's, or parent/guardian 2's place of employment. If there is no answer,
3. The school will call the other telephone number(s) listed and the physician.
4. If none of the above answer, the school will call an ambulance, if necessary, to transport the student to a local medical facility.
5. Based upon the medical judgment of the attending physician, the student may be admitted to a local medical facility.
6. The school will continue to call the parents, guardians or physician until one is reached.
7. The information on this form may be shared with emergency medical staff.

If I cannot be reached and the school authorities have followed the procedures described, I agree to assume all expenses for moving 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.

Parent/Guardian Signature: _____ **Date:** _____

For Office Use Only:	Student:		ID:	

PARENT/GUARDIAN CONTACT INFORMATION

First Name:		Relationship:	☐ Mother ☐ Father ☐ Step-Mother ☐ Step-Father ☐ Court Appointed Guardian ☐ Other (please list):
Middle Name:			
Last Name:			
Generation:	☐ Jr. ☐ Sr. ☐ II ☐ III ☐ IV ☐ V	Living With:	☐ Yes ☐ No
Street Address:		Home Phone:	
Apt #:		Cell Phone:	
Development:		Work Phone:	
City, State, Zip:		Birth Date:	
Education Level: High school diploma/GED or above:	☐ Yes ☐ No	Employer:	
E-Mail:			

First Name:		Relationship:	☐ Mother ☐ Father ☐ Step-Mother ☐ Step-Father ☐ Court Appointed Guardian ☐ Other (please list):
Middle Name:			
Last Name:			
Generation:	☐ Jr. ☐ Sr. ☐ II ☐ III ☐ IV ☐ V	Living With:	☐ Yes ☐ No
Street Address:		Home Phone:	
Apt #:		Cell Phone:	
Development:		Work Phone:	
City, State, Zip:		Birth Date:	
Education Level: High school diploma/GED or above:	☐ Yes ☐ No	Employer:	
E-Mail:			

First Name:		Relationship:	☐ Mother ☐ Father ☐ Step-Mother ☐ Step-Father ☐ Court Appointed Guardian ☐ Other (please list):
Middle Name:			
Last Name:			
Generation:	☐ Jr. ☐ Sr. ☐ II ☐ III ☐ IV ☐ V	Living With:	☐ Yes ☐ No
Street Address:		Home Phone:	
Apt #:		Cell Phone:	
Development:		Work Phone:	
City, State, Zip:		Birth Date:	
Education Level: High school diploma/GED or above:	☐ Yes ☐ No	Employer:	
Email:			

EMERGENCY CONTACT INFORMATION: Must be 18 years of age or older.

Important: In the event of an emergency, individuals listed here will be contacted if parent/guardian **cannot** be reached.

First Name:		First Name:	
Last Name:		Last Name:	
Relationship:		Relationship:	
Home Phone:		Home Phone:	
Cell Phone:		Cell Phone:	
Work Phone:		Work Phone:	