GREAT OAKS CHARTER SCHOOL WILMINGTON

Student:_____ DOB:_____

Student Health History and Updates

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

Please check if your child has had difficulty with any of the following. Please explain under "Comments".

____ADD/ADHD	____Asthma/Respiratory	____Bleeding	____Bone/Spine
____Bowel/Bladder	____Emotional/Behavior	____Diabetes	____Chicken Pox
____Hearing/Ears	____Heart	____Infections	____Kidney
____Physical Disability	____Seizures	____Skin	____Vision/Eyes

Comments:_____

_____

_____

1. Does your child have allergies to: ___Medicines ___Food ___Insect ___Latex ___Dust/Mold ___Other ____No Known Allergies
   To What? _____ What Happens?_____

   Treatment:_____
   A Food Allergy Action Plan completed by a licensed healthcare provider is required for all students with food allergies.
   An Asthma Action Plan completed by a licensed healthcare provider is required for all students diagnosed with asthma.
2. Has your child had any illnesses/surgeries since school ended in June? ____Yes ____No
   What:_____ When:_____
3. Has your child had any immunizations since school ended in June? ____Yes ____No
   List immunizations/dates:_____
4. Is your child being treated or evaluated for any health conditions: ____Yes ____No
   List condition_____
5. Has your child ever been examined by an Eye Doctor? ____ Yes ____ No
   Date of last exam_____
   Glasses Prescribed? ____ Yes ____ No
6. Has your child had any emotional upsets since school ended in June? ____Yes ____No
   List:_____
7. What is the date of his/her last dental exam? _____
8. What is the date of his/her last physical exam? _____
9. Does your child need to take any medications/treatments during the school day?_____ Yes ____ No
   Name of medication/treatments_____
   ***If yes, please contact the school nurse to make arrangements and complete appropriate consent form/s.**

2022/2023

Emergency Treatment Data Card

Student's Name_____

Last Name First Name M.I.

Home Address_____ **Home Phone**_____

Mother/Guardian's Information

Name_____ Cell Phone_____

Home Address_____ Work Phone_____

Email_____

Father/Guardian's Information

Name_____ Cell Phone_____

Home Phone_____ Work Phone_____

Email_____

Emergency contact if parents/guardians cannot be reached and are allowed to pick-up your child from school (Photo ID will be required). Please provide daytime phone numbers.

Name_____ Relationship_____ Phone_____

Family Physician _____ Phone_____

Family Dentist _____ Phone_____

Family Eye Physician _____ Phone_____

Medical Insurance: _____ Group# _____

I verify that all of the above information is correct.

This information may be shared on a "need to know" basis with school personnel and emergency medical staff.

SCHOOL EMERGENCY PROCEDURES

Great Oaks Wilmington School has adopted the following procedures in caring for a student when he/she becomes ill or injured at school:

In case of other emergencies 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 father's, mother's or guardian'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.

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.

I give permission for my child to have the medication/s "Checked" below as determined by the nurse.

____Acetaminophen (Tylenol) ____Ibuprofen (Advil, Motrin) ____Benadryl ____O.T.C. Topical/Lotions

____Sore Throat Spay

Parent/Guardian Signature_____ **Date**_____