

**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".

- |  |   |                                     |                                      |
|--|---|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> ADD/ADHD            | <input type="checkbox"/> Asthma/Respiratory | <input type="checkbox"/> Bleeding   | <input type="checkbox"/> Bone/Spine  |
| <input type="checkbox"/> Bowel/Bladder       | <input type="checkbox"/> Emotional/Behavior | <input type="checkbox"/> Diabetes   | <input type="checkbox"/> Chicken Pox |
| <input type="checkbox"/> Hearing/Ears        | <input type="checkbox"/> Heart              | <input type="checkbox"/> Infections | <input type="checkbox"/> Kidney      |
| <input type="checkbox"/> Physical Disability | <input type="checkbox"/> Seizures           | <input type="checkbox"/> Skin       | <input type="checkbox"/> 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.**

# 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 \_\_\_\_\_

