Great Oaks Student Emergency Treatment Data Card 2025-2026

Student's Last Name: _____Student's First Name: _____Student Middle Initial_____

PARENT/GUARDIAN INFORMATION	
Name: _____	Name: _____
Relationship: _____	Relationship to Student: _____
Home Address: _____	Home Address: _____
Home Phone: _____	Home Phone: _____
Cell Phone: _____	Cell Phone: _____
Place of Employment:_____	Place of Employment:_____
Work Phone: _____Ext: _____	Work Phone: _____Ext: _____

Emergency contact if parents/guardians cannot be reached and can 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 with school personnel and emergency medical staff on a "need to know" basis.

SCHOOL EMERGENCY PROCEDURES

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

In case of other emergencies and/or need for 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 answers, the school will call an ambulance, if necessary, to transport the student to a local medical facility.
5. Based on 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 that 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, Mortin) ____ Benadryl ____ O.T.C. Topical/Lotions

____Sore Throat Spray ____Cough Drops ____Pepto Bismol ____Tums

Parent/Guardian Signature_____ Date_____

July 2025

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/Reiratory ___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: ___Medincines ___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 the appropriate consent form/s.

July 2025