Wilson Elementary Medical History and Treatment Form

STUDENT: _____ **GRADE:**_____ **DATE OF BIRTH:** _____

PARENT/GUARDIAN:_____ **CELL PHONE:** _____

WORK PHONE: _____

A. My child has a food/ insect/ medication ALLERGY: ☐ **NO** ☐ **YES**

Allergy to :_____

B. Please note any health problem, physical handicap, emotional difficulty, behavioural problem:

_____

C. Has your child ever been hospitalized for a medical condition? ☐ **NO** ☐ **YES**

What was the diagnosis? _____

D. My child's immunization/shots are current and up to date: YES ☐ **NO** ☐

E. My child has the following issues or common complaints:

☐ Asthma	☐ Sensitive Skin	☐ Eczema/ Dry Skin	☐ Frequent Nosebleeds
☐ Ear Aches	☐ Sinus	☐ Seizures/ Convulsions	☐ High Blood Pressure
☐ Dizziness/Fainting	☐ Frequent Colds	☐ Headaches/Migraines	☐ Depression/Anxiety
☐ Tonsillitis/Throat	☐ ADHD/ ADD	☐ Hearing/Vision	☐ Heart Problems
☐ Eye Infections/Allergy	☐ Bronchitis	☐ Urinary Problems	☐ Diabetes

F. My child wears glasses ☐ Yes ☐ No Contact lenses ☐ Yes ☐ No

G. Medications: In case of a minor illness, **my child may receive the following medications from the School Nurse**:

☐ Tylenol/ Acetaminophen for pain/fever	☐ Motrin/ Ibuprofen for severe pain/high fever
☐ Antibiotic ointment for scrapes/cuts	☐ Bactine for cleaning scrapes/cuts/ pain
☐ Hydrogen peroxide for cleaning scrapes/cuts	☐ Calamine/Calagel lotion for rashes/ itching
☐ Antacid tablet for upset stomach/nausea	☐ Sterile eye wash
☐ Cough drops for sore throat/ cough	☐ Benzocaine gel for tooth pain
☐ Campho-phinique gel for insect bites	☐ Vick's Chest Rub for cough/headaches

H. My child has a dietary restriction: ☐ **Yes** ☐ **No** Explain: _____

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I hereby give permission to the Wilson School District Nurse to provide necessary treatment for my child and to contact me at the above contact information in the event of an emergency.

Parent/Guardian signature: _____ Date: _____