



Wilson Elementary Medical History and Treatment Form 2021-2022

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:

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Sensitive Skin | <input type="checkbox"/> Eczema/ Dry Skin | <input type="checkbox"/> Frequent Nosebleeds |
| <input type="checkbox"/> Ear Aches | <input type="checkbox"/> Sinus | <input type="checkbox"/> Seizures/ Convulsions | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Depression/Anxiety |
| <input type="checkbox"/> Tonsillitis/Throat | <input type="checkbox"/> ADHD/ ADD | <input type="checkbox"/> Hearing/Vision | <input type="checkbox"/> Heart Problems |
| <input type="checkbox"/> Eye Infections/Allergy | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Urinary Problems | <input type="checkbox"/> 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 or a person designated by the school principal:** (please mark)

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

H. My child has a dietary restriction: () Yes () No Explain: _____

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: _____