Please do not complete this form. This form is to be used as a reference only.

(1) OFFICE OF SCHOOL HEALTH
SH-10

(2) School
(3) Date
(4) Dear Parent/Guardian of
(5) Class
(6) DOB
(7) Subject: **Medical Room Visit**
(8) OSIS

(9) **Your child was seen in the medical room today at ____ AM/PM for:**

- (a) Abrasion
- (b) Ache/Pain
- (c) Allergy symptoms
  - (d) Eyes: Itchy/Red/Teary
  - (e) Nose: Itchy/Runny/Stuffy/Sneezing
  - (f) Throat: Scratchy/Itchy
- (g) Bite
- (h) Cut
- (i) Cough/Cold
- (j) Earache: Right/Left
- (k) Eye: Right/Left
- (l) Vision Problem: Right/Left
- (m) Fever (°F)
- (n) Headache/Dizziness
- (o) Nausea/Vomiting
- (p) Nosebleed
- (q) Pain
- (r) Rash
- (s) Skin: Itchy/Dry/Irritation
- (t) Sore Throat
- (u) Stomachache
- (v) Tiredness/Fatigue
- (w) Toothache
- (x) Trauma
- (y) Other (specify)

(10) **Treatment given:**

- (a) Ice Pack
- (b) Band-Aid
- (c) Cold Compress
- (d) Meal/Snack
- (e) Pressure to stop bleeding
- (f) Area cleaned with soap & water
- (g) Fluids: Water/Juice

(11) **Recommendations:**

- (a) Please see your doctor/dentist for an evaluation
- (b) Keep at home until temperature is normal for 24 hours
- (c) Keep at home until eyes are free of discharge
- (d) Keep at home until vomiting has stopped for 24 hours
- (e) Update your emergency card for parental contact **(we were unable to reach you)**
- (f) Submit **New Admission Physical Exam (CH205)**

(12) **Please contact your Health Care Provider for evaluation:**

- (a) If your child complains of headache, dizziness, nausea, and/or sleepiness
- (b) If area of complaint becomes swollen and/or very painful
- (c) If pain and/or condition continues

(13) **Additional Comments**

(14) **SEEN BY:** (Name and Title)
(15) **TEL. #**

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For translation assistance with this form, please contact your school or make use of an automated translation tool.