



Wilson Primary School Medical History and Treatment form

WILSON
PRIMARY SCHOOL

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 principal: (Please Circle)

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

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

I hereby give permission to the Wilson School District Nurse or authorized personnel 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: _____