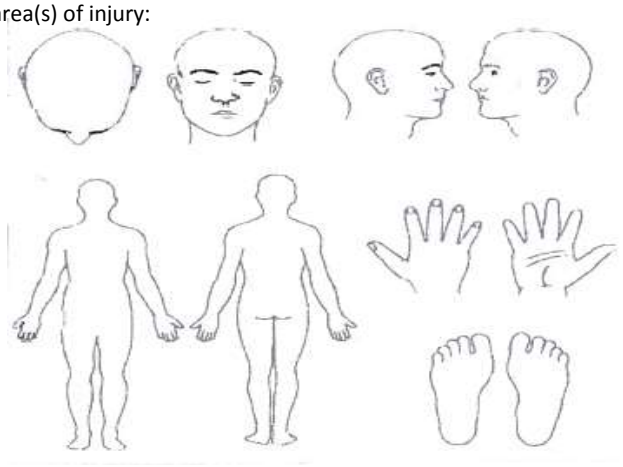
ILLNESS/INJURY REPORT

School: _____

DATE:

NAME:	**GR/RM #:**		**Time In:**	**Time Out:**
	DOB:	**M / F**	**VITALS**	
			BP:	**T:**
Dear Parent/Guardian: Your child reported to the Health Counselor's Office today for the following reason(s).			**O2 Sat:**	**P:**
			Pain Scale:	**R:**

	INJURY				**ILLNESS**			
	Abrasion/scrape		Bruise/bump		Colds		Breathing difficulties
	Cut laceration		Puncture		Cough		Earache
	Suspected sprain/fracture		Bee Sting/Insect bite		Sore throat		Eye irritation
	Nose bleed		Possible dislocation		Headache		Toothache
	Other				Stomachache		Nausea
Location when injury occurred:					Vomiting		Diarrhea
					Rash/hives		Dizziness
Mark area(s) of injury:					Fever		Other



Comments:_____

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Treatment /Care Administered

	Soap/Water		Warm Compress		Ice Pack		Juice/water
	Bandage		Pressure Dressing		Made to rest		Referred to Admin
	Prescribed Medication		Splint/Sling		Repeat V/S		Referred to Counselor
	Other:						
Parent/Guardian Notified:					Time:		

Instructions/Recommendations/Disposition

	Recommend rest and fluids.			
	I recommend that you observe your child carefully and take him/her to the doctor if deemed necessary.			
	I recommend that you take your child and this form to the doctor or clinic as soon as possible.			
	Your child may return to school when fever free for 24 hours without fever reducing medications.			
	Must provide a written clearance from a doctor or medical provider before returning to school.			
	Head injury precautions: Be alert for symptoms that worsen over time. Take your child to the ER right away if you observe any loss of consciousness, convulsions, headaches, dizziness, nausea, vomiting, slurred speech, drowsiness, and/or changes in personality.			
	Please keep injury clean and dry and observe for signs of infection (redness, swelling, yellow discharge, increased pain and temperature)			
	911 called Time:_____ Time EMS arrived in school: _____		Returned to class	Sent home
	Refused EMS Transport: _____ Print Name _____ Signature _____ Relationship			

Signatures	**Medical Report and Diagnosis:**
School Admin/Designee:	
School Health Counselor:	
(I acknowledge and understand the recommendations and instructions from the SHC) **Parent/Guardian:**	

Physical restrictions:
Medications:

Physician's Signature:_____ Date: _____ Clinic Name/Number/Stamp: _____

REVISED 8/17/16