(2) School
(4) Dear Parent/Guardian of
(7) Subject: Medical Room Visit
(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

(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. #

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