STUDENT INJURY/ILLNESS FORM

STUDENT INFORMATION

Student Name		Date			
Date of Birth		Grade		Male	Female
Check in Time		Check out Time			

SCHOOL INFORMATION

School:	Principal:

ILLNESS/INJURY COMPLAINT (CHECK ALL THAT APPLY)

	Allergic reaction		Diarrhea		Head injury		Sickle cell
	Abrasion/Scratch		Difficulty breathing		Heat illness		Sore throat
	Asthma concern		Dislocation		Hypothermia/Frostnip		Splinter
	Behavioral health concern		Dizzy		Menstrual problems		Sting
	Bleeding		Ear problem		Mouth/Jaw injury		Stomach ache
	Bite		Eye problem		Nose injury		Tick
	Blister		Facial sore		Nosebleed		Toenail injury
	Burn		Fainting		Not feeling well		Vomiting
	Cough		Fever		Pain:		Other:
	Cut/Laceration		Fingernail injury		Puncture		
	Dental problem		Fracture		Rash		
	Diabetes concern		Headache		Seizure		

TREATMENT PROVIDED (CHECK ALL THAT APPLY)					
	Bandaid/Bandage		Medication administered:		Snack given
	Cool compress applied x 15 min		Notified School Nurse	✔	Temperature checked: 103.2
	Eye flushed		Parent/Guardian notified		Wound care
	Fluids given		Pressure applied x 15 min		Other:
	Heating pad applied x 15 min		Rest: 15 minutes		

ADDITIONAL CARE PROVIDED

DISPOSITION (CHECK ALL THAT APPLY)			
	EMS/911 called		Sent/Taken Home
	Parent decided to remove from school		Taken to healthcare provider/clinic/hospital/urgent care
	Return to class		Other:

Signature of school staff_____ Date: _____