Town of Fairfield School Health Program

Child's Name:

Date:

Dear Parent:

Your child was seen by me today at for:

□Cough	□Bee Sting
□Earache	□Foreign Body in Eye
□Headache	□Tick
□Nausea	□Splinter
□Sore Throat	□Stomach Ache
□Tooth Ache	□Bloody Nose

□Discomfort/Pain:
□Injury:
□Other:

□First aid treatment was given:
□I was unable to contact you.
□I was unable to reach your emergency contacts.
□I recommend watching for further problems.
□I recommend consulting your doctor.
□Other recommendations:

Should you have any questions, please contact me at

School Nurse/School Health Aide

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