NURSE REFERRAL

Date _____ Time Sent _____ Arrived _____

Student's Name _____

Teacher's Name _____

Reason for visit:

____ earache
____ check temperature
____ head check
____ headache
____ injury
____ sore throat
____ stomach ache
____ toothache
____ vomiting
____ other _____

_____

_____

Findings: _____

_____

_____

Nurse Response:

____ May return to class. Send back to clinic if symptoms get worse or persist.
____ Contacted parents. _____
____ Will be going home. Please send any assignments home.

____ **Parent/Guardian:** If you have questions about your child's condition, we suggest you consult your family doctor.
Thank you,

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