

### NURSE REFERRAL

Date \_\_\_\_\_ Time Sent \_\_\_\_\_ Arrived \_\_\_\_\_

Student's Name \_\_\_\_\_

Teacher's Name \_\_\_\_\_

**Reason for visit:**

- |                                            |                                       |
|--------------------------------------------|---------------------------------------|
| <input type="checkbox"/> earache           | <input type="checkbox"/> sore throat  |
| <input type="checkbox"/> check temperature | <input type="checkbox"/> stomach ache |
| <input type="checkbox"/> head check        | <input type="checkbox"/> toothache    |
| <input type="checkbox"/> headache          | <input type="checkbox"/> vomiting     |
| <input type="checkbox"/> injury            | <input type="checkbox"/> 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.

Time Out: \_\_\_\_\_

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