



Nurse Referral Form

Date: _____ Time Sent To Nurse: _____
Student Name: _____ Teacher: _____ Grade: _____
Parent's Name: _____ (H) # _____ (W) # _____
Time Sent Back To Class: _____

PLEASE CHECK ONE OF THE FOLLOWING:

- checkbox Lice checkbox Eye Swollen checkbox Rash checkbox Fever
checkbox Diarrhea checkbox Injury* checkbox Stomachache checkbox Cough
checkbox Earache checkbox Nosebleed checkbox Vomiting
checkbox Other: _____

*Please describe injury: _____

Nurse's Assessment & Treatment:

Please Check:

- checkbox Parents Notified checkbox Student Sent Back To Class checkbox Student Sent Home

Table with 2 columns: Teacher's Signature, Nurse's Signature

After student has been seen by nurse, a completed copy of the referral will be sent to the school's office to be filed in the student record.