

NURSE/CLINIC REFERRAL

DATE: _____

TIME: _____

STUDENT: _____ GRADE: _____ TEACHER: _____

COMPLAINT:

- Cold/Cough/Throat _____
- Nosebleed _____
- Breathing _____
- Rash _____
- Eyes/Ears/Mouth _____
- Headache/Dizzy _____
- Stomach/Nausea _____
- Hair _____
- Medication _____
- Other _____

ACTION:

- Temperature _____
- S.E.T. Called _____
- Parent-Guardian Called/Sent Home _____
- Rest in Clinic _____
- Returned to Class _____
- Referral Made _____
- Ice _____
- Other _____

COMMENTS: _____

Seen by Nurse: _____ Date: _____

Seen by Staff: _____ Date: _____

Reviewed by Nurse: _____ Date: _____