

Clarksville-Montgomery County School System

HEALTH SERVICES

Clinic Referral

Student's Name	Grade	Date
Teacher's Name	Time to Clinic	

CHECK OR WRITE REASON FOR REFERRAL

<input type="checkbox"/> Stomachache <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Ear ache <input type="checkbox"/> Bleeding <input type="checkbox"/> Rash on _____ <input type="checkbox"/> Toothache/loose tooth <input type="checkbox"/> Other _____	<input type="checkbox"/> Headache <input type="checkbox"/> Sore Throat <input type="checkbox"/> Cold symptoms/Coughing <input type="checkbox"/> Eye injury/Foreign body <input type="checkbox"/> Injury to _____
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NOTE: NURSE WILL NOT PULL TEETH

NURSE'S REPORT TO TEACHER

	Time to class
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Student is without fever, may return to class
 Parent notified of student's condition. Student to return to class
 Unable to contact parent/guardian (will continue to try). Student to return to class
 Send student back to clinic at _____.
 Send student back to clinic if _____.
 Student will be dismissed according to Guidelines for Dismissal (HEA-F043).
 Student will be dismissed per parent.

Comments _____

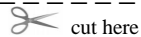
NURSING ASSESSMENT and ACTIONS

<input type="checkbox"/> Temp	<input type="checkbox"/> Pulse	<input type="checkbox"/> Lung Sounds
<input type="checkbox"/> Ice	<input type="checkbox"/> Wound care/Band-Aid	<input type="checkbox"/> Bleeding controlled
<input type="checkbox"/> Reassurance	<input type="checkbox"/> Vaseline/Lotion	<input type="checkbox"/> Warm salt water gargle
<input type="checkbox"/> Splint	<input type="checkbox"/> Cold/Warm Compress	<input type="checkbox"/> Health Education
<input type="checkbox"/> Rested	<input type="checkbox"/> Eye wash	<input type="checkbox"/> Medication (See M.A.R.)
<input type="checkbox"/> Rest, Ice, Compression, Elevation		
<input type="checkbox"/> Head Check (findings <input type="checkbox"/> lice <input type="checkbox"/> nits <input type="checkbox"/> clear)		
<input type="checkbox"/> Clinic note	<input type="checkbox"/> Parent/Guardian note	<input type="checkbox"/> Student Injury Report

ASSESSMENT _____

COMMENTS _____

Nurse's Signature _____



NURSE'S REPORT TO TEACHER

Student's Name	Time to class
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Comments _____

Nurse's Signature _____