STUDENT HEALTH REFERRAL

Name: _____ Date:_____ Time Sent: _____

Referring Adult:_____

Complaint: Specified by student, teacher or parent

____ Asthma	____ Headache	____ Sore throat	____ Burn
____ Head Injury	____ Joint Injury	____ Cut/Laceration	____ Insect Bite
____ Possible Fracture	____ Earache	____ Stomach Discomfort	____ Eye Problem
____ Seizure	____ Cold Symptoms	____ Possible Fever	____ Skin Problem
____ Vomiting/Diarrhea	____ Personal	____ Other: _____	

Comments: _____

Observations: _____

Vital Signs @ _____ Temp _____ BP _____ Pulse _____ Resp _____ LOC _____ PERRLAEOM _____
as needed: @ _____ Temp _____ BP _____ Pulse _____ Resp _____ LOC _____ PERRLAEOM _____

Nursing Diagnosis (NANDA): _____

Plan: _____

Intervention (NIC):___ Rested ___ Elevation ___ Wound Care ___ Injury immobilized ___ Cold Application ___ Observed ____ Other

Health Counseling: _____

Evaluation (NOC): _____

Resolution: _____ Return to class @ _____
_____ Return to class for belongings. Send back to Nurse's Office.
_____ Remain in Nurse's Office
_____ Referral to Physician

Parents Notified: ___ No ___ Yes Telephone @ _____ Message left with_____
___Note sent home

Please:

[ ] Observe for_____
[ ] Have your child evaluated by a licensed health care provider. (Form attached)
[ ] Read attached health information.

Re-admittance criteria:

a. Fever free for 24 hours after school exclusion for temperature 100F or greater
b. No significant nausea, vomiting, or diarrhea for 24 hours
c. Chicken pox (Varicella) lesions crusted and dry, at least 5-7 days from onset
d. Lice treatment initiated
e. Impetigo lesions covered and under care of medical provider
f. Conjunctivitis, signs of infection have cleared
g. Ringworm covered, under care of medical provider
h. Scabies, 8 hours after first prescribed treatment

"Insert name and title"

1) Retain original in nurse's office 2) Copy for Parent/Physician 3) Copy for Teacher