Fresno County
Superintendent of Schools

Health Services
Alma McKenry, Senior Director

Health Referral

Child's Name:_____ DOB:_____ Grade:_____ Date:_____

Dear Parent: _____

_____

_____

_____

_____

We recommend that you consult your health care provider about this matter. Please have him give his report on the lower part of this form. **Please return this referral to your school nurse.** For additional information, please call_____ on *(nurse available)* ☐ M ☐ T ☐ W ☐ Th ☐ F between the hours of _____ and _____.

SCHOOL STAMP

_____
School Administrator

_____
School Nurse

Physician's Report

Finding and/or diagnosis:_____

_____

Recommendations for care:_____

_____

Referred to another health advisor? ☐ Yes ☐ No Whom:_____

Child under medication/treatment? ☐ Yes ☐ No Whom:_____

Return visit? ☐ Yes ☐ No When:_____

Referred to another health advisor? ☐ Yes ☐ No Whom:_____

Suggestion for school nurse/school personnel:_____

_____

*Date:*_____ *Physician's Signature:*_____ *Telephone #*_____

Thank you for completing and returning this form (via parents or mail) back to the school. This information will be helpful in planning the educational program of this student.

Enclosure: ☐ Yes ☐ No