Clarksville-Montgomery County School System
Health Services
Clinic Referral

Date: _____ Time to Clinic: _____ Student Name: _____

Teacher's Name: _____ Grade: _____

REASON FOR REFERRAL

- ☐ stomach ache
- ☐ nausea/vomiting
- ☐ ear ache
- ☐ rash on _____
- ☐ injury to _____
- ☐ toothache/loose tooth*
- ☐ sore throat
- ☐ cold symptoms/cough
- ☐ eye injury/foreign body
- ☐ headache
- ☐ bleeding

Nurse will not pull teeth or repair braces

☐ other: _____

NURSING OBSERVATION & INTERVENTION

- ☐ temp ☐ BP ☐ bleeding controlled
- ☐ SPO2 ☐ pulse ☐ wound care/Band-Aid
- ☐ ice ☐ lung sounds
- ☐ reassurance ☐ RR ☐ cold/warm compress
- ☐ splint ☐ eye wash ☐ health education
- ☐ rested ☐ medication (see M.A.R)
- ☐ feminine products ☐ warm salt water gargle/candy
- ☐ rest, ice, compression, elevation
- ☐ head check: ☐ lice ☐ nits ☐ clear
- ☐ Parent/Guardian note ☐ Student Injury Report
- ☐ Clinic note ☐ Parent/Guardian contacted by phone
- ☐ other: _____

Observation/Nursing Notes*

(Please document the time of any pertinent information, i.e., parent/guardian contact, when checking vital signs, etc.):

***USE BACK OF PAPER IF NEEDED**

_____ _____ _____

Nurse's Signature Date Time to Class

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Nurse's Signature Date Time to Class

2/15/16, Rev. I HEA-F037