Clarksville Montgomery County School System
HEALTH SERVICES
BLOOD PRESSURE REFERRAL

Name _____ Date _____

Grade _____ Teacher _____

Dear Parent:

Your child recently participated in a blood pressure screening mandated by the State of Tennessee. A follow up by your physician is indicated. The results of this examination will assist school personnel in making all necessary modifications to your child's educational program.

Blood Pressure (BP) Screening

Systolic: _____

Diastolic: _____

Date of Examination _____ School Nurse _____

This form should be completed by the examining physician and **returned to the school nurse.**

Diagnosis: _____

Examination Results

Systolic: _____

Diastolic: _____

Recommendations and remarks_____

Re-evaluation of this patient has been recommended in: _____ Months _____ Year

_____ _____
Physician Name (please print) Physician Signature

_____ _____
Address Date of Examination

_____ _____ _____
City State Zip Telephone Number Fax Number