MEDICAL REFERRAL FORM

Name___ Date of Birth_____

Date_____Time_____a.m./p.m.

Where did injury occur?_____

How did injury occur? Collision with_____

Hit by_____Fell on/from_____

Other_____

Date of last known tetanus shot:_____

Part of body injured (indicated L or R for left or right when applicable):

☐ Ankle	☐ Eye	☐ Hip	☐ Nose
☐ Arm	☐ Face	☐ Knee	☐ Scalp
☐ Back	☐ Finger	☐ Leg	☐ Shoulder
☐ Chest	☐ Foot	☐ Lip	☐ Stomach
☐ Collar Bone	☐ Hand	☐ Mouth	☐ Tooth
☐ Elbow	☐ Head	☐ Neck	☐ Wrist

☐ Other (specify)_____

Illness

Complaint_____

Assessment_____

Comments:_____

Nursing Intervention/Comments:_____

Parent/guardian/Relative Caregiver advised: of injury/illness Yes _____ No _____
to seek medical attention: Yes _____ No _____

Signature: _____, School Nurse Date:_____

Phone:_____

PLEASE COMPLETE AND RETURN TO SCHOOL NURSE:

Examining Licensed Healthcare Provider:_____ Date:_____

Diagnosis:_____

Treatment:_____

Send copy of emergency card if transporting to Emergency Room

March 2017