



**MEDICAL REFERRAL/FOLLOW-UP FORM**

Dear Parent or Guardian:

While examining your child, a problem was noted. We suggest that you take your child along with this form to the doctor of your choice for recommendations regarding the possible health problem indicated below. We are anxious to give you any assistance we can in getting your child's problem corrected and thank you for your cooperation.

School Name \_\_\_\_\_ /Phone# \_\_\_\_\_ Nurse Name \_\_\_\_\_

Dear Medical Provider:

We have checked:

Name: \_\_\_\_\_ School: \_\_\_\_\_ Grade: \_\_\_\_\_  
who, in the routine of our School Health Services, presents the following type problem: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Please indicate the severity and prognosis of the condition you find and advise us of the need for any limitation of activity, prosthesis, or any action we might pursue to improve the health of this child.

Our observations are as follows: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Date: \_\_\_\_\_ Nurse: \_\_\_\_\_ Phone \_\_\_\_\_

Days in School \_\_\_\_\_

Professional Opinion and Recommendations: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medical Professional's Signature: \_\_\_\_\_ Phone: \_\_\_\_\_ Date: \_\_\_\_\_

Is there any specific time you wish to see this student again? Yes: \_\_\_\_ No: \_\_\_\_ When? \_\_\_\_\_

Parental consent: I consent to and authorize the health care provider to disclose the above information to those within the school district who have a need to know for legitimate educational purposes. **If information is confidential, please return in the mail to:** Coordinator of Health Services, 6125 E. Belknap, Fort Worth, Texas 76117; otherwise, return through channel received.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_