THE SCHOOL DISTRICT OF PHILADELPHIA

REPORT OF VISIT TO HEALTH SERVICES

M-34 (Rev. 3/07) Comm. Code 61602445241

STUDENT'S LAST NAME	FIRST NAME	DATE	
NAME OF SCHOOL		GRADE	ROOM / BK. NO.

TO THE PARENT / GUARDIAN:

The School Nurse reports that your child was seen in the health room for the illness/injury indicated below:

___ Headache	___ Sore throat	___ Minor cut / Abrasion	___ Bump/bruise
___ Stomachache	___ Pencil/pen stick	___ Major cut	___ Emotional/behavioral issue
___ Nausea/vomiting	___ Joint injury	___ Head injury (MEH-51 attached)	___ Menstrual cramps
___ Other_____	___ Eye injury		

■ Treatment: ___ Ice ___ Acetaminophen ___ Ibuprofen ___ Cleansed/Bandage ___ Rest ___ Counseled

___ Physical Exam completed by School Physician/School Nurse Practitioner

*Comments:*_____

_____

_____

_____

■ Recommended follow up - contact your doctor*:

___ At once for emergency treatment
___ As soon as possible
___ If condition does not improve
___ Note from doctor is required
___ Other _____

_____

** If you take your child to the doctor, please ask your doctor to complete the back of this form and return it to the School Nurse as soon as possible.*

SIGNED - SCHOOL NURSE	PHONE NUMBER	SIGNED - SCHOOL PHYSICIAN/SCHOOL NURSE PRACTITIONER

REPORT BY FAMILY DOCTOR

DIAGNOSIS:

TREATMENT:

DATE OF FOLLOW-UP VISIT:_____

DOCTOR'S SIGNATURE	DATE SIGNED
DOCTOR'S PRINTED NAME	PHONE NUMBER

REPORT BY PARENT / GUARDIAN

PARENT'S SIGNATURE	DATE SIGNED

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