POMONA UNIFIED SCHOOL DISTRICT
HEALTH SERVICES & PROGRAMS
REFERRAL FOR HEALTH CARE

Child's Name: _____ Grade: _____Date: _____

Dear Parent:

Your child needs follow-up care for _____

_____

_____

_____ 1. Your child may return on _____, only if well for 24 hours.

_____ 2. Your child must be cleared by the school nurse/health assistant before returning.

_____ 3. Please have your doctor/dentist complete the lower portion of this form.

_____ 4. Please sign below so the doctor/dentist can supply needed information.

Parent Signature: _____ Date:_____

TO BE COMPLETED BY DOCTOR/DENTIST

Date examined by Doctor/Dentist: _____

Doctor/Dentist Signature: _____ Phone: _____

Diagnosis and/or special instructions: _____

_____

_____

Treatment plan: _____

_____

_____

PLEASE RETURN FORM TO: **SCHOOL NURSE:** _____

SCHOOL: _____

ADDRESS: _____

_____

TELEPHONE: _____