

Form must be returned to School Nurse

**HARVEST PREPARATORY SCHOOL**

DOCTOR'S DIAGNOSIS REQUEST FORM

STUDENT'S NAME _____	DATE _____
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Dear Parent/Guardian,

Today your child was seen in the HPS Student Health Clinic. Since we were not able to determine if your child's condition was contagious or serious, we are asking that you take your child to the pediatrician or physician and have the child examined for the following concerns:

- \_\_\_\_\_ 1. SKIN/RASH \_\_\_\_\_
- \_\_\_\_\_ 2. EYE/PINK/OTHER \_\_\_\_\_
- \_\_\_\_\_ 3. COLD/FLU SYMPTOMS \_\_\_\_\_
- \_\_\_\_\_ 4. COUGHING \_\_\_\_\_
- \_\_\_\_\_ 5. INJURY/PAIN \_\_\_\_\_
- \_\_\_\_\_ 6. OTHER \_\_\_\_\_

**PLEASE HAVE THE DOCTOR COMPLETE THE FOLLOWING INFORMATION AND SIGN BELOW. THIS FORM MUST BE SUBMITTED TO THE OFFICE WHEN THE CHILD RETURNS TO SCHOOL.**

NAME OF PHYSICIAN \_\_\_\_\_  
PHONE NUMBER \_\_\_\_\_  
DIAGNOSIS OF CONDITION \_\_\_\_\_  
CONTAGIOUS/SPECIAL INSTRUCTIONS \_\_\_\_\_  
DATE PERMITTED TO RETURN TO SCHOOL \_\_\_\_\_

**Signature of Physician** \_\_\_\_\_

**THANK YOU!**

SCHOOL NURSE _____	PHONE <u>837-1990 x 402</u> <b>HPS HEALTH CLINIC FORM 9/2012</b>
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