APPENDIX E: Sample Forms

♦ School Health Encounter Forms—Clinic Visits, Report to Parents, Nurse’s Notes
♦ Dental—Referral Form
♦ Scoliosis—Explanation/Parent Authorization Form
♦ Scoliosis—Referral Form
♦ Injury—Student Injury Report Form
NEWPORT NEWS PUBLIC SCHOOLS

CLINIC VISITS

Name of Student: ____________________________

Last               First

Date of Birth: ____________________________

Phone Number: ____________________________

Name of Parent or Guardian: ____________________________

Last               First

<table>
<thead>
<tr>
<th>DATE</th>
<th>TIME</th>
<th>NATURE OF ILLNESS, CARE GIVER, DISPOSITION OF CASE.</th>
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<tbody>
<tr>
<td>Month-Day-Year</td>
<td>In</td>
<td>Out</td>
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<td>INITIALS OF CARE GIVER</td>
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B: Clinic v31
Newport News Public Schools
Health Services

CLINIC REPORT TO PARENTS

School _____________________________ Date ____________

Name ____________________________________________

To Parent or Guardian:

Your child was in the clinic today complaining of:

( ) stomachache ( ) earache
( ) headache ( ) injury
( ) sore throat ( ) other

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

If your child continues to have problems, you should have him/her checked by a physician.

_____________________________________
Health Services Representative
# Nurse's Notes

Student's name ____________________

D.O.B. ____________________

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<tr>
<th>Date</th>
<th>Name</th>
<th>Signature/Title</th>
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8/95
CHESTERFIELD COUNTY HEALTH DEPARTMENT
SCHOOL HEALTH SERVICES

DATE: ________________

Dear Parent/Guardian:

A dental screening was given __________________ on ________________.

The results of the screening indicate your child may have a dental problem that may need to be evaluated by a dentist. If your child is under the care of a private dentist, please indicate below and return this form to the school or have the dentist complete the form at your child’s next visit. This information is necessary in order that your child’s school health profile may be kept up-to-date.

If you do not have a family dentist, you may telephone the Dental Clinic located at Chesterfield Health Department at 748-1752 regarding dental resources.

Sincerely,

________________________
Public Health School Nurse

STUDENT: ___________________ SCHOOL: ___________________

TEACHER: ___________________ GRADE: ___________________

☐ UNDER DENTAL CARE

__________________________  _______________________
Parent’s Signature    Date

Dear Doctor:

Please complete the report below:

NAME: ___________________ SCHOOL: ___________________

FINDINGS RECOMMENDATIONS: ____________________________________

☐ CORRECTED  ☐ BEING TREATED

__________________________  _______________________
Date    Dentist’s Signature

Return this form to:
Chesterfield Health Department
P. O. Box 100
Chesterfield, VA 23832

7/97
Date

Dear Parents of Fifth Grade Pupils:

In the next few weeks, the Norfolk Public Schools and the Norfolk Health Department will conduct a Scoliosis Screening program to find the children who have abnormal curvatures of the spine. According to current medical information, scoliosis most commonly occurs in children in the 9 to 14 year age group. Seven to ten of every hundred children may develop some degree of scoliosis and one to three of this group may require treatment. If the condition is detected early and appropriately treated, progressive deformity of the spine can be prevented, and the child can be protected from the emotional and physical pains of deformity. The procedure for screening is a simple one in which the screener, the School Health Nurse, looks at the child’s back while he or she is standing or is in the forward bending position. The proper screening procedure is shown on the back of this letter.

If your child has a possible abnormal curvature, you will be notified and asked to take your child to your family physician, pediatrician, or orthopedist for diagnosis. If you should receive such a notice, you should take your child to the doctor as soon as possible; delay could result in the need for an operation.

You must return the bottom portion of this letter indicating your approval or disapproval of your child’s participation.

Sincerely yours,

Superintendent of Schools

Norfolk Health Department

Director

THIS FORM MUST BE RETURNED TO THE SCHOOL OFFICE THE DAY AFTER RECEIPT.

NORFOLK PUBLIC SCHOOLS

NORFOLK HEALTH DEPARTMENT

I [ ] do want my child

I [ ] do not want my child

_________________________  ______________, to participate in the curvature of the

Name                        Age

spine screening program.

Signature of Parent or Guardian

Telephone:  ______________  Address:  ______________

SCHOOL ADMINISTRATION BUILDING, POST OFFICE BOX 1357, NORFOLK, VIRGINIA 23501
NORFOLK PUBLIC SCHOOLS
NORFOLK PUBLIC HEALTH DEPARTMENT

REFERRAL LETTER—SCOLIOSIS SCREENING

Dear Parent:

Your child ___________________________ participated in our school scoliosis screening program.

Although the results do not definitely mean that there is a problem or that treatment is needed, you are urged to take your child to your family physician, pediatrician or orthopedist for an examination.

The cause of scoliosis (curvature of the spine) is unknown. It becomes more apparent during adolescence and often can be corrected if discovered and treated early.

Please request the examining physician to complete this form. When your child has completed his/her examination (and you have signed the parent signature line*) please return this referral to the school nurse.

Thank you for your cooperation. Please feel free to call me if you have any questions.

Sincerely,

_________________________ School Health Nurse

PHYSICIAN’S FINDINGS AND RECOMMENDATION:

I have examined ______________________ on ______________________

( ) Standing (anterior-posterior x-ray) shows: ______________________

( ) No significant findings at this time ______________________

( ) Need for further evaluation ______________________

( ) Re-examination or treatment recommended (if so, Date ______________________)

Additional Comments: ______________________

________________________________________ M.D.

_________________________ Address

_________________________ Telephone No.

*Parent’s Signature Line
# Henrico County Schools
## Student Injury Report Form

This form is to be completed immediately following the occurrence of any injury that is serious enough to warrant parental notification. Additional instructions on back.

1. Child's name ____________________________
2. Parent's name ____________________________
3. School name ____________________________
4. School ____________________________

<table>
<thead>
<tr>
<th>Days Absent</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) Less than 1/2</td>
<td></td>
</tr>
<tr>
<td>(b) 1/2</td>
<td></td>
</tr>
<tr>
<td>(c) 1</td>
<td></td>
</tr>
<tr>
<td>(d) 1 1/2-2</td>
<td></td>
</tr>
<tr>
<td>(e) 2 1/2-3</td>
<td></td>
</tr>
<tr>
<td>(f) If more than 3 days, then specify #</td>
<td></td>
</tr>
</tbody>
</table>

11. Action Taken: PLEASE CHECK AND COMPLETE ALL THAT APPLY:

<table>
<thead>
<tr>
<th>Time</th>
<th>By Whom (List title code) (Title codes on back)</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>9. (Called 911)</td>
<td>Includes Triage/Rescue</td>
<td>9. (Called 911)</td>
</tr>
</tbody>
</table>

12. Action Taken: PLEASE CHECK AND COMPLETE ALL THAT APPLY:

13. Nature of Injury: List the injuries/symptoms incurred. (Record # in boxes at left.)


14. Area Affected: List area affected for each injury/symptom code listed in 13 above. (Record # in boxes at left.)

<table>
<thead>
<tr>
<th>Head</th>
<th>Trunk</th>
<th>Extremities</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Ear</td>
<td>5. Mouth/Tongue/Up</td>
<td>8. Head</td>
</tr>
<tr>
<td>25. Knee</td>
<td>26. Leg</td>
<td>27. Toe</td>
</tr>
</tbody>
</table>

15. Cause of Injury: List main cause of the injury. (Record # in boxes at left.)

| 1. Animal bite (dog bite, etc.) | 4. Contusion by sharp edge/object | 7. Foreign body in eye, ear, nose |
| 2. Collision with object/person | 5. Fall | 10. Struck by object |
| 3. Contact with fire, hot liquid/object | 6. Fight/Roughhouse | 8. Jam/Crush/Pinch |
| 9. Motor vehicle crash | | |

16. Period: List period during which injury occurred. (Record # in boxes at left.)

| 1. After school (authorized) | 3. Athletic event | 5. Before school (authorized) |
| 11. Reclass | 12. Title | 88. Other |

17. Surface: List surface on which injury occurred. (Record # in boxes at left.)

| 1. Not applicable | 3. Carpet | 5. Grass/Dirt |
| 7. Hardwood Floor | 8. Ice/Snow | 10. Mulch/Wood chips |

18. Location: List location at which injury occurred. (Record # in boxes at left.)

| 2. Bus loading area | 5. Coordinator (exclude stadium) | 8. Lab (Home Ec., Chem., etc.) |
| 10. Multipurpose Room | 11. Playground/Playfield | 12. School bus/Public bus |
| 88. Other | 99. Unknown | |

19. Activity: List activity during which injury occurred. (Record # in box at left.)


20. Equipment: Was equipment or apparatus involved in injury? Yes ☐ No ☐ Specify equipment.

21. Underlying medical condition(s)? Yes ☐ No ☐ Specify.

22. Description: Describe specifically how the injury happened and treatment provided.

23. Signature of person making report ____________________________
24. Title code ____________
25. Principal's signature ____________________________

Rev 8/97
Number title of form 910026-0-1

748
Henrico County Schools
Student Injury Report Form Instructions

This form is to be completed immediately following the occurrence of any injury that is serious enough to warrant parental notification.

**Item #**

1–10  Self explanatory.

11  If student is going to be absent for an extended period of time, use parent’s estimate. If no school is missed, check less than 1/2.

12  **Check and complete all that apply.** List title code (from the codes that follow) and name of person(s) who perform first aid and who notify parents.

**Title Codes**

1. Advisor/Counselor
2. Assistant Principal
3. Bus Driver
4. Clinic Attendant
5. Coach
6. Paramedics / EMT
7. Principal
8. School Nurse
9. Secretary/Office Aid
10. Substitute Teacher
11. Teacher (excluding Coach)
12. Trainer
88. Other

13  Of the injuries the child sustained, list whichever is the most severe in the box labeled "more severe" (even if you consider the injury to be minor). The other box is used only if there is more than one injury to the child.

14  List the area affected in the "more severe" box that corresponds to the injury listed in the "more severe" box in #13. Do the same for the less severe box.

15–16  Self explanatory. **Choose one answer only.**

17  Describe surface over which injury occurred (i.e. surface upon which child fell or on which child was standing, running, playing, etc. at the time of injury). **Choose one answer only.**

18–19  Self explanatory. **Choose one answer only.**

20  If yes, specify type of equipment or apparatus.

21  If there was some type of underlying medical condition that possibly contributed to the injury incident, please specify.

22  Briefly describe specifically how the incident happened and the treatment provided. If there were witnesses, please list names at the end. **If additional space is needed, continue on another sheet of paper and attach.**

23  Self explanatory.

24  Choose one of the codes listed above.

25  Self explanatory.

Retain original in school. Send copy to: