

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

HS-PC-7

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

The Newport News School Division does not discriminate on the basis of race, color, national origin, sex, creed, marital status, age, or disability in its programs, activities, or employment practices as required by the Title VI, Title VII, Title IX, Section 504, and ADA regulations. *Crawford Smith*, Assistant Superintendent, Personnel Services at 12465 Warwick Boulevard, Newport News, VA 23606, (804-591-4550), is responsible for coordinating the division's efforts to meet its obligations under Section 504, Title IX, the ADA, and their implementing regulations.

**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

SAMPLE

NORFOLK PUBLIC SCHOOLS
NORFOLK PUBLIC HEALTH DEPARTMENT

REFERRAL LETTER—SCOLIOSIS SCREENING

Date _____

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.

	Poss. Abnorm.
1.	_____
2.	_____
3.	_____
4.	_____
5.	_____

	Ortho-team Check
1.	_____
2.	_____
3.	_____
4.	_____
5.	_____

Sincerely,

School Health Nurse
School: _____

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: _____

Signed _____ 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 _____	5. Date of birth ____/____/____ mo day yr	8. Date of injury ____/____/____ mo day yr
2. Parent's name _____	6. Grade _____	9. <input type="checkbox"/> Male <input type="checkbox"/> Female
3. School name _____	7. Time of injury ____ <input type="checkbox"/> am <input type="checkbox"/> pm	10. Fatal <input type="checkbox"/> Yes <input type="checkbox"/> No
4. School # _____		

11. Days absent: *Record letter of the DAYS absent from school related to this injury in box at left.*

<input type="checkbox"/> a) Less than 1/2	<input type="checkbox"/> b) 1/2	<input type="checkbox"/> c) 1	<input type="checkbox"/> d) 1 1/2-2	<input type="checkbox"/> e) 2 1/2-3	<input type="checkbox"/> f) If more than 3 days, then specify # _____
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12. Action Taken: **PLEASE CHECK AND COMPLETE ALL THAT APPLY.**

	Time	By Whom (List title code.) (Title codes on back)
1. <input type="checkbox"/> First aid administered	____ <input type="checkbox"/> am <input type="checkbox"/> pm	____ Specify name _____
2. <input type="checkbox"/> Parent or guardian notified	____ <input type="checkbox"/> am <input type="checkbox"/> pm	____ Specify name _____
3. <input type="checkbox"/> Unable to contact parent/guardian	____ <input type="checkbox"/> am <input type="checkbox"/> pm	
4. <input type="checkbox"/> Remained in or returned to class		9. <input type="checkbox"/> Called 911
5. <input type="checkbox"/> Sent/taken home		10. <input type="checkbox"/> Taken to M.D., health care provider, hospital, etc. Diagnosis _____
6. <input type="checkbox"/> Parents deemed no medical action necessary		11. <input type="checkbox"/> Hospitalized. Specify length _____
7. <input type="checkbox"/> Checked by school nurse		12. <input type="checkbox"/> Restricted school activity. Specify length _____
8. <input type="checkbox"/> Checked by clinic attendant		88. <input type="checkbox"/> Other, specify _____

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

<input type="checkbox"/> More Severe	1. Abrasion/Scrape	5. Cut/Laceration	9. No Pulse	13. Shortness of Breath
<input type="checkbox"/> Less Severe	2. Bump/Bruise/Contusion	6. Dislocation (possible)	10. Not Breathing	14. Sprain/Strain/Tear
	3. Burn/Scald	7. Fracture/Broken (possible)	11. Pain/Tenderness Only	15. Swelling/Inflammation
	4. Contusion (possible)	8. Loss of Consciousness	12. Puncture	88. Other _____

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

	Head	Trunk	Extremities						
<input type="checkbox"/> More Severe	1. Chin/Cheek	4. Forehead	7. Nose	10. Stomach	13. Chest/Ribs	16. Internal	19. Ankle	22. Finger/Thumb	25. Knee
<input type="checkbox"/> Less Severe	2. Ear	5. Mouth/Tongue/Lip	8. Head	11. Back	14. Collarbone	17. Pelvis/Hip	20. Arm	23. Foot	26. Leg
	3. Eye	6. Neck/Throat	9. Tooth/Teeth	12. Buttocks	15. Genitalia	18. Shoulder	21. Elbow	24. Hand/Wrist	27. Toe

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

<input type="checkbox"/>	1. Animal bite (dog bite, etc.)	4. Contact with sharp edge/object	7. Foreign body in eye, ear, nose	10. Struck by object	88. Other _____
	2. Collision with object/person	5. Fall	8. Jam/Crush/Pinch	11. Tripped/Slipped	99. Unknown
	3. Contact with fire, hot liquid/object	6. Fight/Roughhouse	9. Motor vehicle crash		

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

<input type="checkbox"/>	1. After school (authorized)	3. Athletic event	5. Before school (authorized)	7. Class time (exclude P.E.)	9. Lunch	11. Recess	99. Unknown
	2. Assembly	4. Athletic practice session	6. Class change	8. Field trip	10. P.E. class	88. Other _____	

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

<input type="checkbox"/>	1. Not applicable	3. Carpet	5. Grass/Dirt	7. Hardwood Floor	9. Mats	11. Sand	88. Other _____
	2. Blacktop	4. Concrete	6. Gravel	8. Ice/Snow	10. Mulch/Wood chips	12. Tile	99. Unknown

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

<input type="checkbox"/>	1. Athletic field	4. Classroom	7. Gymnasium	10. Multipurpose Room	13. Sidewalk/Stairs/Ramp	88. Other _____
	2. Blacktop	5. Corridor (exclude stairs)	8. Lab (Home Ec., Chem., etc.)	11. Playground/Playfield	14. Street/Driveway/Parking area	
	3. Bus loading area	6. Doorway	9. Lunchroom	12. School bus/Public bus	15. Restroom	99. Unknown

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

<input type="checkbox"/>	1. Baseball/Softball	6. Dodge ball	11. Jumping/Skipping	16. Roughhousing	21. Standing	27. Wrestling
	2. Basketball	7. Fighting	12. Kickball	17. Setting up/Moving equipment	22. Swinging	88. Other _____
	3. Bicycling	8. Flag/Touch football	13. Lab/Shop activities	18. Sliding	24. Tennis	99. Unknown
	4. Classroom activity	9. Football	14. Riding bus	19. Sitting	25. Volleyball	
	5. Climbing bars	10. Gymnastics/Tumbling	15. Running	20. Soccer	26. Walking	

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. _____ 24. Title code _____ 25. _____
 Signature of person making report Principal's signature

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

- 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: