\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_County/City Schools

Report of Eating Disorder Screening

Dear Parent/Guardian:

Eating disorder screening was conducted on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (date).

The results of screening indicate your child may need to be evaluated by your primary health care provider. Early diagnosis and intervention for persons experiencing an eating disorder is very important. The screening conducted at school is **not** a diagnosis, but an indication that further evaluation may be needed by a qualified health care professional.

If you do not have a primary health care provider or need assistance with finding a health care professional to assess your child for an eating disorder, please contact the school nurse at: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

If you have questions regarding screening or your child’s results, please contact, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (name and number of contact).

STUDENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SCHOOL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TEACHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GRADE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ I have received this referral and will follow up with my health care provider

□ I would like more information on eating disorders screening, results, and/or resources

□ My child is under the care of his/her primary health care professional and/or eating disorders

specialist

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Parent/guardian signature Date

6/13