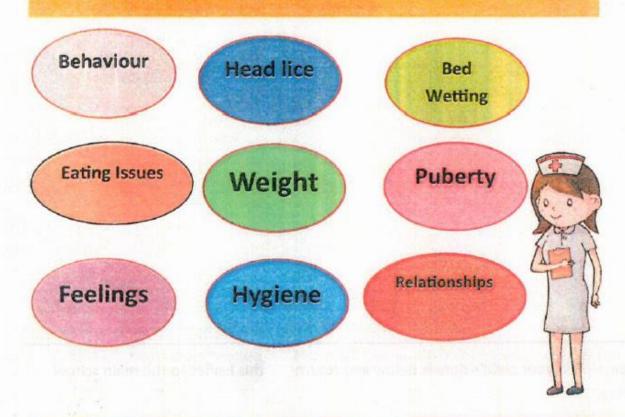


YOUR SCHOOL NURSE IS VISITING

DID YOU KNOW YOUR SCHOOL NURSE PAYS US A VISIT EVERY TERM?

Your school nurse can help with many concerns and she can also be a great support alongside your usual doctor. The school nurse can guide you to get the right help or support with the following;



If you have any concerns about your child, no matter how big or small, that you would like to discuss with the School Nurse please fill out the form overleaf. The school will contact you for more details and let you know when the School Nurse is next visiting

| Please fill in your child's details below and return office. | this leaflet to the main school |
|--|---------------------------------|
| Childs Name | |
| Date of Birth | |
| Class | |
| Parents Name | |
| Contact Number | |

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Appendix 3

Referral form to be used by the school for all children/young people contacts with the school nursing team e.g. drop in sessions.

SCHOOL REFERRAL FORM INTO SCHOOL NURSING

| Name of Child: | Child's Date of Birth | 1: | Gender: M/F Ethnicity: | |
|---|-----------------------|---|---------------------------|--|
| Child's Address: | | NHS Numb | | |
| Child's School and Address: | Child's GP, Address | Child's GP, Address & Tel No.: | | |
| Parent/Carer's Name: | Day-time contact no | Day-time contact number: | | |
| Parental Responsibility: | | Is the above named child a Looked After Child/Child Protection? Yes / No | | |
| Reason for request (please use additional sheet | et if necessary)? | | | |
| | | | | |
| | | | | |
| | | | | |
| Name of professional making this referral (Prin | t Name): | | | |
| Professional's Signature: | Professional's Title | | | |
| Designation/School: | | | | |
| Professional's Contact No: | Email address: | | | |
| | | | | |

| THIS SECTION MUST BE COMPLETED BY PROFESSIONALS | | |
|---|--|--|
| *Is the Parent/Carer of the above named child aware of this referral? | | |
| *Does the Parent/Carer understand the reason for this referral? | | |
| *If answered no to either of the above questions please contact the School Nursing Team to discuss. | | |

| THIS SECTION MUST BE COMPLETED BY PARENT/CARER/COMPETENT CHILD | | | |
|--|--|--|--|
| | | | |
| Date: | | | |
| Date | | | |
| | | | |
| n, LU3 3QB | | | |
| | | | |

SRF/SCHNURSE Nov15