Alachua County Public Schools

Health Services

Referral to: _____

Name:_____

Address:_____

DOB:_____ Grade:_____ Race:_____

School:_____

Special Education Category:_____ Insurance Company:_____

Parent/Guardian:_____

Home Phone:_____ Work Phone:_____

Detailed Complaint and Symptoms:

Referred by:_____ Phone:_____

Prior TX: Yes ☐ No ☐ Where?_____

Parental Permission

I understand and give my permission for the following:

- ☐ That my child may be seen in the _____
- ☐ That medical and school records of my child may be exchanged between Alachua County Public Schools and the _____

_____ _____

Parent/Guardian Signature *Date*

Copies of the following to be forwarded to clinic prior to appointment:

Clinic Appointment Date/Time:_____ Phone:_____

Medical Exam

Summary of Findings:

Recommendations/Medications:

_____ _____

Physician Signature *Date*