San Francisco Unified School District
Student Support Services Department
1515 Quintara St.
San Francisco, CA 94116
Tel. 415/242-2615
Fax: 242-2618
www.healthiersf.org

SAN FRANCISCO SFUSD UNIFIED SCHOOL DISTRICT

SCHOOL NURSING REFERRAL

Student: _____ ___ ___
Last **First** **Middle** **M** **F**

_____
Address/Apartment number

_____ _____
Telephone number **Birth date**

_____ _____
Parent/Caregiver **Home Language(s)**

_____ _____ _____
School **Telephone** **Teacher** **Grade**

PLEASE ATTACH A COPY OF THE STUDENT'S EMERGENCY CARD

REASON FOR REFERRAL:

PLEASE INDICATE THE INTERVENTIONS MADE PRIOR TO THIS REFERRAL AND THE OUTCOMES: (We suggest initial contact by school staff before referral is made)

HISTORY: Briefly state related health and social information (medications, activity limitations, special diet, classroom behavior, social interaction, etc.)

_____
Referral Made By Title

_____
Signature of Site Administrator Date

SEND TO:
School Nursing Referral
Student Support Services Department
1515 Quintara Street
San Francisco, CA 94116
Fax: 415-242-2618