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

Request for School District Nursing Consultation

Student: _____ ____
Last **First** **Middle** **M /F**

_____ _____ _____ _____
School **Grade** **Birth Date** **Ethnicity**

_____ _____
Address/Apartment Number/City/Zip **Parent/Caregiver/Guardian**

_____ _____
Parent/Caregiver Telephone Number(s)/Email **Home Language(s)**

Program: ☐ **General Education** ☐ **Section 504** ☐ **Special Education** ☐ **Other:** _____

REASON FOR REFERRAL: Briefly state student's medical condition(s) or diagnosis that may require a health assessment and/or health-related services.

HISTORY: Briefly state related health and social information (activity limitations, special diet, classroom behavior, social interaction, etc.) (attach another sheet if needed)

PROCEDURES, MEDICATION, EQUIPMENT & ACCOMMODATIONS: Briefly state any current specialized healthcare procedures (include frequency & time of day), medications (include route, frequency & time of day), medical equipment, transportation accommodations, etc.) (attach another sheet if needed)

Emergency Card: ☐ No ☐ Yes (please attach)
Release of Information: ☐ No ☐ Yes (please attach)
Health Documents: ☐ No ☐ Yes (please attach) (care plans, medical records, etc.)

If applicable:

_____ _____ _____ _____ _____
SST Date **Initial IEP/504 Date** **Triennial Date** **IEP Date** **Special Ed/504 Eligibility Designation**

_____ _____
Case Manager **Case Manager Email /Telephone/ Fax**

☐ **Check here if you wish a case consultation before the School Nurse's initial contact with the family.**

↘ _____
Request for Consultation Made By (Name) **Title/Position** **Phone/Email** **Referral Date**

Please email completed form to the SFUSD Nurse of the Day (call 415-242-2615 for email) or fax to 415-242-2618.

 Date Received by SHP: _____