THE SCHOOL DISTRICT OF PHILADELPHIA **REPORT OF VISIT TO HEALTH SERVICES** M-34 (REV. 3/2000) Comm. Code 61602445241	STUDENT'S LAST NAME FIRST NAME & M.I.	DATE OF ISSUED	
	NAME OF SCHOOL	GRADE	ROOM / BK. NO.

TO THE PARENT / GUARDIAN:

The School Nurse / Physician reports that your child:

- ☐ **CAME TO THE HEALTH ROOM ON ____________ WITH THE PROBLEM / INJURY LISTED BELOW:**
- ☐ **WAS EXAMINED ON ____________ AND FOUND TO BE WELL WITH NO PROBLEMS.**
- ☐ **WAS EXAMINED ON ____________ AND THE FOLLOWING PROBLEMS WERE FOUND:**

1. ________________________
2. ________________________
3. ________________________
4. ________________________

Recommended follow-up – contact your doctor:

- ☐ **AT ONCE FOR EMERGENCY TREATMENT**
- ☐ **AS SOON AS POSSIBLE FOR EVALUATION AND TREATMENT**
- ☐ **IF CONDITION DOES NOT IMPROVE**
- ☐ **DOCTOR'S NOTE REQUIRED**

Please ask your doctor to complete the back of this form and to return it to the School Nurse as soon as possible.
If a physician has not seen your child, please explain reason on the back and return it to the School Nurse.

SIGNED – SCHOOL NURSE	SIGNED – SCHOOL PHYSICIAN M.D. D.O.	SIGNED – PRINCIPAL

REPORT BY FAMILY DOCTOR

DIAGNOSIS:

TREATMENT:

DATE OF FOLLOW-UP VISIT:__________

DOCTOR'S SIGNATURE	DATE SIGNED
DOCTOR'S PRINTED NAME	PHONE NUMBER

REPORT BY PARENT / GUARDIAN

PARENT'S SIGNATURE	DATE SIGNED