HEALTHY CPS

— OFFICE OF STUDENT HEALTH & WELLNESS —

MEDICAL REFERRAL

(LAST NAME) (FIRST) (MIDDLE) (DOB) (ID #)

(HOME ADDRESS) (ZIP CODE) (TELEPHONE)

(PARENT'S/ GUARDIAN'S NAME) (SCHOOL)

Dear Healthcare Provider,

We are requesting your assistance in identifying health information which may impact the above named student during school hours. This student is being referred because of the following:

Please use the attached sheet to document your findings and return the completed form to the school nurse promptly.

Sincerely,

School Nurse Signature_____ * Date _____

HEALTHY CPS

— OFFICE OF STUDENT HEALTH & WELLNESS —

MEDICAL PROVIDER'S REPORT/RECOMMENDATIONS

(LAST NAME) (FIRST) (MIDDLE) (DOB) (ID #)

(HOME ADDRESS) (ZIP CODE) (TELEPHONE)

(PARENT'S/ GUARDIAN'S NAME) (SCHOOL)

Diagnosis and Prognosis:

Recommendations:

Providers's Name_____ **Hospital Affiliation** _____

(Please print or type)

Address _____**Telephone #** _____**Fax #**_____

Provider's Signature _____ **Date** _____

Chicago Public Schools

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