300 S Washington
P. O. Box 890
Lexington, Nebraska 68850-0890
(308) 324-4681

Date________________________________

PARENT/GUARDIAN: I give permission for any relevant health information of my child, necessary for
PADRE(S) O TUTOR(ES): DOY MI PERMISO PARA QUE TODA INFORMACIÓN DE SALUD PERTINENTE A MI

educational planning and/or student safety, to be shared among appropriate school personnel who serve the
NIÑO Y NECESARIA PARA LA PLANIFICACIÓN EDUCATIVA O SEGURIDAD ESTUDIANTIL, SEA COMPARTIDA ENTRE EL PERSONAL DE LA ESCUELA QUE ATIENDE

student (for example; nurses, teachers, coaches, or staff member administering medication).
AL ALUMNO (POR EJEMPLO; ENFERMERAS MAESTROS, ENTRENADORES, O MIEMBRO DEL PERSONAL QUE ADMINISTRE ALGÚN MEDICAMENTO).

Please have the Dr. fill out this form and have your student return it to the school.
POR FAVOR HAGA QUE EL MÉDICO LLENE Y FIRME ESTE FORMULARIO Y REGRÉSELO A LA ESCUELA.

____

(Parent/Guardian Signature) (Firma paternal o del tutor)

DR: Today, during examination of _____________________________________, we identified the following concerns:

____

____

____

____

Please help us with follow-up care of this student, by providing us the following information:

Physician's Findings:

______No significant findings at this time

______Need for further evaluation

______Child is contagious & should be excluded from school for ________days

______Re-examination or treatment recommended on (date)_____________________________

Additional comments:____

____

____

Dr. or Dentist Signature____

Thank You!

Phys referral. doc