**SATIT PRASARNMIT INTERNATIONAL PROGRAMME**

**176 Soi Sukhumvit 23, Wattana, Klongtoey-nue, Bangkok 10110**

**Tel. 02260-9621-3 Fax. 02260-9621 ext. 717**

**REQUEST FOR SCHOOL NURSE CONSULTATION**

**Individuals submitting request please complete selections A and B Return to School Nurse. Thank you.**

A

Date of Request\_\_\_\_\_\_\_\_\_\_\_\_\_ Period\_\_\_\_\_\_\_ Time\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Requested by (Teacher name)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Teacher Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

B **Request Consultation for (circle the symptom):**

Headache Earache Stomach Ache Toothache Insect Bite/Sting

Temperature Cough Nosebleed Rash/ Itch Sore Throat

Cramps Diarrhea Vomiting Injury Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

✄-----------------------------------------------------------------------------------------------------------------------------**School Nurse Use Only**

Date of Request\_\_\_\_\_\_\_\_\_\_\_\_\_ Period\_\_\_\_\_\_\_ Time\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Finding/Plan\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Return to class time\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Return to nurse time \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent notified\_\_\_\_\_\_\_\_\_\_\_ Time \_\_\_\_\_\_\_\_\_\_

Sent Home \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time \_\_\_\_\_\_\_\_\_\_

 Nurse’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_