|  |
| --- |
| **REFERRAL TO SCHOOL HEALTH SERVICE**  |
| Date of Referral: | Date Referral Received by School Health Service: |
| Child’s Name and DOB: | Name of Referrer:Designation: |
| Name of School and Class: |  |
| Name of Parents/Carers: Address:Parental Consent: Y / N Phone number:Date consent received: Interpreter required: Y / N Consent received by whom: Language: |
| Nature of Concern: |
| Action already taken:(e.g. discussed with parent / carer, SENCO, Head Teacher) |
| Other Professionals Involved: |
| Action Required of School Health Service: |
| **Please forward this referral to the visiting school nursing staff to collect from a designated area in the school** **or send directly to the duty desk at:** **cnw-tr.kandcshs.cnwl@nhs.net** |
| **SCHOOL NURSING SERVICE FEEDBACK TO REFERRER:** |
| Name and Signature of School Health Professional:Designation: | Name:Signature: |
| Date: |  |