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| **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**](mailto:cnw-tr.kandcshs.cnwl@nhs.net) | | |
| **SCHOOL NURSING SERVICE FEEDBACK TO REFERRER:** | | |
| Name and Signature of School Health Professional:  Designation: | | Name:  Signature: |
| Date: | |  |