2019/2020

CLINIC VISIT ROGERSVILLE CITY SCHOOL 116 BROADWAY ROGERSVILLE, TN 37857 (423) 272-7651	STUDENT'S NAME	GRADE/HR	DATE
	NATURE OF VISIT ☐ INJURY ☐ ILLNESS ☐ OTHER	TIME OUT OF CLASS	
		TIME IN CLINIC	TIME OUT CLINIC

REASON FOR VISIT:

☐Tele-Health	☐ Earache	☐Nosebleed	☐Congestion	☐Cough
☐Headache	☐Eye Pain	☐Dizziness	☐Sore Throat	☐Asthma
☐Stomachache	☐Nausea/Vomiting	☐Diarrhea	☐Rash	☐Toothache

TEACHER COMMENTS:_____

_____

Time:	Temp:	B/P:	Pulse:	Pulse Ox:
Resp:	Weight:	Height:	BMI:	Peak Flow:

	NL	ABN	Comments		NL	ABN	Comments
Skin				Neck			
Neuro			No Distress ☐	Lymph Nodes			
Eyes				Lungs/Chest			
Nose				CV/Heart			
Ears				Abdomen			
Mouth/Throat				Orthopedic			
				Musculoskeletal			

ASSESSMENT: _____

_____

PLAN: _____

_____

Parent/Guardian Name:_____**Phone #**_____**1st Call**_____**2nd Call**_____**3rd Call**_____

Verbal Consent To Treat: Yes ☐ No ☐ Pharmacy:_____ **Allergies:**_____

Nurse Notes: _____

_____

_____

_____

Signature _____ **RN**