CLINIC VISIT ROGERSVILLE CITY SCHOOL 116 Broadway Rogersville, TN 37857 (423) 272-7651	Student's Name:	Grade/HR:	Date:
	Sent by (Faculty/Staff Name):	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
❑ Other:				

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: _____

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Signature_____**RN**