

☐ School Nurse
Acalanes H.S.
1200 Pleasant Hill Rd.
Lafayette CA 94549
Fax 925-280-3971

☐ School Nurse
Campolindo H.S.
300 Moraga Rd.
Moraga, CA 94556
Fax 925-280-3951

☐ School Nurse Las Lomas H.S. 1460 S. Main St. Walnut Creek, CA 94596 Fax 925-280-3921 ☐ School Nurse Miramonte H.S. 750 Moraga Way Orinda, CA 94563 Fax 925-280-3931

Doctor's Office Visit

	was seen on		at
(Student Name)		(Date)	(Time)
Please include summary of student's curren	t medical condition ar	nd any schoo	I instructions below:
Diagnosis:			
Treatment			-
Medications required at school			
Precautions/restrictions			
Future evaluations/follow up appointments:			
Other pertinent information:			
Authorizing MD SIGNATURE:			Date:
MD Name, Address and			
 This information may be released to school 	ol staff as needed.		
Parent/Guardian Acknowledgement:			
(Parent/Guardian Signature)	Date:		