Annapolis Valley Regional School Board
Working Together for Students

Students with Life Threatening Allergies

Referral Form

Student Health Partnership Program (SHPP)

Referral Form for Registered Nurse

Please fax to 902-697-2320 or e-mail to karen.bartlettnoiles@avrsb.ca

Student Information

Student's Name:	DOB (dd-mm-yyyy):	Health Care Number: Medical Alert Number:
Parent(s)/ Guardian(s):	Phone: (H) (W) (C) E-mail:	
Student's Address		

School Information

School:	Grade:	Phone:	Fax:
Person making referral:			
Diagnosis and reason for request (Please attach relevant medical information available):			

This section must be completed by parent(s)/guardian(s)

Additional comments/information:	
Family Physician	Other health care providers:

Parent /Guardian Permission:

I do herby give consent to the referral of my child to the SHPP Registered Nurse for review of his/her health care needs as they relate to the school environment. As well, I give my permission for the Registered Nurse to discuss my son/daughter's health care needs with associated Health Care Professionals as deemed appropriate by the Registered Nurse. I understand that after this assessment, the SHPP Registered Nurse will discuss the identified health concerns with me as well as the School's Program Planning Team.

Parent/Guardian Signature:	Date:
Principal's Signature:	Date:
Date Referral Submitted:	
E-mail address of Primary Contact:	

For Office Use Only

Date received at AVRSB: _____ Date received by Registered Nurse: _____