ST. LUCIE PUBLIC SCHOOLS
HEALTH SERVICES CLINIC FORM

To:____ **Date:** ___/___/___
PARENT OR GUARDIAN

On _____________________________, **your child** ______________________________
Was seen in the school clinic for the following reason(s):

Your attention to the matter mentioned above will be appreciated.
Please sign and return this form.

____
PARENT/GUARDIAN SIGNATURE

Thank you,

____
HEALTH AIDE
______________/_____________
SCHOOL/PHONE

White: Parent/Guardian
Yellow: Health Aide

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