



Winton School District
Request for Health Services
Non-Emergency Needs

School Site _____

Date: _____

STUDENT NEEDS

___ Health Concern: ___ Dental ___ Vision ___ Hearing ___ Other
___ SST ___ IEP (___ Initial ___ Annual ___ Triennial) ___ Health History

Student _____ Teacher _____

Address _____ Phone _____

Reason for Request:

STAFF NEEDS

___ In Class Presentation ___ Staff Training ___ Assistance with Health Curriculum
___ Other

Specify Reason or Need

PRIORITY OF NEED

Specific Date _____

Time _____

___ One week or less ___ Within two weeks ___ When possible

Signature of Referral Originator _____

HEALTH SERVICES RESPONSE

___ I will provide the service as indicated

___ I will provide the service, but not until _____

___ Unable to provide the service requested

Reason _____

District Nurse _____ Date _____

Completed Date _____ Comments _____