



310 S. Main St., Bellefontaine, OH 43311
 PH: 937-592-9040 – FX 937-592-4012

RECURRENT HEAD LICE REFERRAL FORM
 Please fill in the below requested information as thoroughly as possible.
 Use the back of the form if necessary

Date _____

Name of person(s) family being referred _____

List age and grade for students _____

Address _____

Phone Number (or contact number) _____

School District _____ Building (s) _____

Parent/Guardian _____

History of Problem (include date 1st identified)

Total # of school days missed due to head lice _____

List dates of absences _____

What interventions (i.e. education, home visits, counseling) have been performed and by whom?

Intervention	By whom/Agency	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____

Signature/title of person making referral _____ Contact number _____

Follow-up report to referring agency _____

Date(s) of follow-up	Intervention(s)	Effect
_____	_____	_____
_____	_____	_____
_____	_____	_____

 Signature/date