Student Health/Wellness Assessment
Out of Classroom Care Hall Pass

You need to completely fill out this form if you think you need to see the nurse.

Student Name:_____ Today's Date:_____ Time:____

Parent/Guardian's Name:_____ Subject:_____

Phone Number:_____ Grade: _____ Room Number:___

Student's Birthday:_____ Teacher:_____

Today's Complaint: (check one)

Headache ☐ Tooth Ache ☐ Diarrhea ☐ Vomiting ☐ Sore Throat ☐

Coughing ☐ Stomach Ache ☐ Menstrual Cramps ☐ Other: _____

Students please complete the following sentence:

I think my problem can be fixed by:_____

_____

(Office Use Only)

Teacher's Signature:_____ Time:_____

Nurse\Office Signature:_____ Returning Time:_____

Disposition\Treatment:_____

Created by Caleb Cheung

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