Health Office Pass

Student Name: ______________________________

Date _____________________ Time: ___________

Teacher ___________________________________

Complaint:

☐ Cold	☐ Skin Condition
☐ Cough	☐ Soiled Clothing
☐ Earache	☐ Sore Throat
☐ Headache	☐ Stomachache
☐ Injury	☐ Temperature
☐ Nose Bleed	☐ Vomiting
☐ Runny Nose	☐ Other

Comments:__________________________________

____

☐ OK to return to class ☐ Going home

Health Office Pass

Student Name: ______________________________

Date _____________________ Time: ______________

Teacher ______________________________________

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☐ Earache	☐ Sore Throat
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Comments:____________________________________

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☐ OK to return to class ☐ Going home

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Comments:___________________________________

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☐ OK to return to class ☐ Going home

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☐ OK to return to class ☐ Going home