NURSE HALL PASS

Teacher: ______________________ **Date:** ______________

Student: ______________________ **Time:** ______________

Needs to see the nurse for:

Temperature__________	Cut/Scrape__________
Headache__________	Stomach Pain__________
Cough/Cold__________	Sores__________
Bruise__________	Rash__________
Vomiting__________	Diarrhea__________
Pencil Stick__________	Injury__________
Head Lice__________	Toothache__________
Earache__________	Other__________

Note to the Parent: Yes No **Treatment:**

Medical Referral: Yes No

Dental Referral: Yes No

Call to Parent: Yes No

Phone Number: ______________

Response: ______________

Time Returned to Class: ____________

Nurse's Signature: ______________________________