NURSE PASS

Student:			
	(First & Last Name	as it is in the computer please)	
Teacher:			
Date:		Time:	
Reason for Nurse Visit:			
	Change of Clothes	Teeth	
	Cough	Eyes	
	Sore Throat	Stomach Ache	
	Ears	Medication	
	Headache	Other	_
	Rash		
Health Services Action:			_
Ticalcii Selvices / ledoiii			_
Returned to Class:	YES / NO (Please Circle)	Time:	_
Temp Checked:	YES / NO (Please Circle)	Temp:	_
Parent Called:	YES / NO (Please Circle)		
Student Referred To:	125 / 115 (Hease Girele)		
Student Nerence 101			
Nurse's Signature:			
J			_
DTN			
1 41	NE TREE ISD NURS	SE PASS	
	NE TREE ISD NURS	SE PASS	
Student:		as it is in the computer please)	
Student:			
Student: Teacher: Date:		as it is in the computer please)	_
Student: Teacher:	(First & Last Name	as it is in the computer please) Time:	_ _ _
Student: Teacher: Date:	(First & Last Name a	as it is in the computer please) Time: Teeth	
Student: Teacher: Date:	(First & Last Name a	Time: Teeth Eyes	
Student: Teacher: Date:	Change of Clothes Cough Sore Throat	Time: Teeth Eyes Stomach Ache	
Student: Teacher: Date:	Change of Clothes Cough Sore Throat Ears	Time: Teeth Eyes Stomach Ache Medication	
Student: Teacher: Date:	Change of Clothes Cough Sore Throat Ears Headache	Time: Teeth Eyes Stomach Ache	
Student: Teacher: Date: Reason for Nurse Visit:	Change of Clothes Cough Sore Throat Ears	Time: Teeth Eyes Stomach Ache Medication	
Student: Teacher: Date:	Change of Clothes Cough Sore Throat Ears Headache	Time: Teeth Eyes Stomach Ache Medication	
Student: Teacher: Date: Reason for Nurse Visit: Health Services Action:	Change of Clothes Cough Sore Throat Ears Headache Rash	Time: Teeth Eyes Stomach Ache Medication Other	
Student: Teacher: Date: Reason for Nurse Visit: Health Services Action: Returned to Class:	Change of Clothes Cough Sore Throat Ears Headache Rash YES / NO (Please Circle)	Time: Teeth Eyes Stomach Ache Medication Other Time:	
Student: Teacher: Date: Reason for Nurse Visit: Health Services Action: Returned to Class: Temp Checked:	Change of Clothes Cough Sore Throat Ears Headache Rash YES / NO (Please Circle) YES / NO (Please Circle)	Time: Teeth Eyes Stomach Ache Medication Other	
Student: Teacher: Date: Reason for Nurse Visit: Health Services Action: Returned to Class: Temp Checked: Parent Called:	Change of Clothes Cough Sore Throat Ears Headache Rash YES / NO (Please Circle)	Time: Teeth Eyes Stomach Ache Medication Other Time:	
Student: Teacher: Date: Reason for Nurse Visit: Health Services Action: Returned to Class: Temp Checked:	Change of Clothes Cough Sore Throat Ears Headache Rash YES / NO (Please Circle) YES / NO (Please Circle)	Time: Teeth Eyes Stomach Ache Medication Other Time:	