HEALTH OFFICE PASS

Name_____

Date_____ Time_____

Complaining of:

☐ Headache ☐ Stomach ache ☐ Sore Throat
☐ Ear ache ☐ Toothache ☐ Eye problem
☐ Other_____

Showing signs of illness:

☐ Coughing ☐ Vomiting ☐ Head down ☐ Drowsy
☐ Other_____

Take Temperature. Results_____

Other_____

_____

Teacher_____

Notes from Health Office_____

_____

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