MOUNT SINAI SCHOOL BASED HEALTH CENTERS

TITO PUENTE EDUCATIONAL COMPLEX

NURSE PASS

STUDENT'S NAME: _____

DATE: ___ / ___ / ___ **TIME:** ___ : ___ **AM / PM**

I am sending the above student to the medical office for:

- ☐ Asthma/Difficulty Breathing
- ☐ Ear Pain
- ☐ Evaluation of Injury
- ☐ Eye Irritation/Redness
- ☐ **First Aid (bandage, ice, etc.)**
- ☐ Headache
- ☐ Menstrual Cramps
- ☐ Nausea/Vomiting
- ☐ Nosebleed
- ☐ Rash
- ☐ Sore Throat
- ☐ Splinter
- ☐ Stomach Pain
- ☐ Other: _____

Comments/Special Instructions

- ☐ Return to Class
- ☐ Return to Main Office
- ☐ Other: _____

_____

Teacher/School Personnel: _____

Student left the medical office at: _____ : _____ AM/PM Office Staff Signature: _____