(This space to be utilized for each school's logo / letterhead)

SCHOOL BOARD OF BROWARD COUNTY CLINIC PASS

Date: _____

Student: _____ ☐M ☐F DOB: _____
LAST FIRST

Teacher: _____ Grade: _____

Contact Phone #s: (1) _____ (2) _____

Reason for Referral: _____

_____

Referred to clinic by: _____ (Time) _____ AM/PM

_____

CLINIC USE ONLY

Time student arrived in clinic: _____ AM/PM

Nature of Complaint:

- ☐ Not feeling well
- ☐ Stomachache
- ☐ Headache
- ☐ Toothache
- ☐ Injury _____
- ☐ Other: _____
  _____
  _____

Action Taken:

- ☐ Student laid/sat in clinic for 20 minutes or less
- ☐ Student laid/sat in clinic for 20 minutes or more
- ☐ Temperature taken
- ☐ Ice Pack applied to affected area
- ☐ Affected area cleaned
- ☐ Band aid applied to affected area
- ☐ Head checked for: _____
- ☐ Parent/Guardian Notified: _____at _____AM/PM
- ☐ 911 called
- ☐ Other: _____

Disposition of student:

- ☐ Returned to class. Feeling better
- ☐ Returned to class at parent's/guardian's request
- ☐ Returned to class unable to contact parent's/guardian's
- ☐ Remained in clinic
- ☐ Sent home ☐ Teacher notified
- ☐ Office clearance required for child to return to class
- ☐ Referral was made to Health Care Provider
- ☐ 911 Transported
- ☐ Copy of clinic pass sent home
- ☐ Other _____

Student left clinic at (Time): _____

Comments: _____

_____

_____

Clinic Action Handled by: _____

White - Clinic Yellow - Parent/Teacher

COMPLETED PASS TO BE FILED IN THE STUDENT'S CUM FOLDER BEFORE THE END OF THE SCHOOL YEAR.