Health Office Visit Request

Student Name:_____ Date: _____

Time In:_____ Time Out:_____

	Illness		**Injury**		**Emotion**
	Cough		Cut		Nervous
	Sore throat		Sprain		Worried
	Breathing difficulty		Pain		Angry
	Fever		Tooth		Sad
	Rash		Bloody Nose		Other:
	Headache		Uncontrolled bleeding		
	Stomach ache		Other:		
	Other:				

I've tried:

_____ Drink of water; _____ Rested head; _____ Bathroom break;

_____ Positive self-talk; _____ 5 deep breaths; _____ Count back from 10;

_____ Other (specify):_____

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