KIDS NIGHT IN
HEALTH CLINIC

MY PATIENT IS A *(circle one)* BOY GIRL

draw a picture of your patient

PATIENT NAME: _____

AGE: _____ WEIGHT: _____

SYMPTOMS *(check the boxes)*

- ☐ HIGH FEVER
- ☐ SLEEPY
- ☐ UPSET STOMACH
- ☐ EYE PAIN
- ☐ COUGH
- ☐ TOOTH PAIN
- ☐ TIRED

TREATMENT PLAN *(check the boxes)*

- ☐ REST
- ☐ SHOT
- ☐ SURGERY
- ☐ MEDICINE
- ☐ BAND-AID
- ☐ OTHER

DIAGNOSIS: _____

SIGNED BY DOCTOR: _____ DATE: _____

your name

Get well soon!

kids
NIGHT IN BOXES