School Based Health Center
Problem List

Date Problem Entered	Date of Onset*	CHRONIC PROBLEMS	Date Inactive

*if different than the date entered

***(P)** Problem Recheck **(PR)** Problem Resolved **(O)** Other

Date of Visit/Code*			ACUTE PROBLEMS (self limiting)
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Discussion	Handout	HEALTH EDUCATION	Date

Allergies: _____ Medications: _____

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DOB: _____ ID# _____ Patient Name: _____