

Absentee Forms

MEDICAL EXCUSE FORM

This form is required ONLY after ten (10) medically excused absences.

STUDENT NAME: _____

I hereby authorize this health care provider to release the information requested on this form for my child listed above. _____
Parent or Guardian Signature

Date of Appointment: _____

Time of Appointment: _____ Time In: _____ Time Out: _____

Reason for Appointment (check only one)

- Routine Office Visit Follow-up Visit Orthodontic
- Dental Vision Emergency Tests

Was it medically necessary for this student to be absent the entire day on date of appointment?

- Yes No

If no, would student have missed all day due to office location, etc?

- Yes No

Will student need to be absent more than one (1) day?

- Yes No

If yes, how long? _____

If student is to be absent five consecutive days or more, please complete a homebound application.

This student may return to school on _____
Date

Health Care Provider: _____

Name of Physician: _____

Address: _____

Phone Number: _____

Signature of Health Care Provider/Physician/APRN

Date

Adopted 8/21/2017