Attendance/Truancy Prevention Forms

MEDICAL EXCUSE FORM

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

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 Comments: ______________________________________

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 or more consecutive days, please complete a homebound application.

This student may return to school on ________________________
Date

Health Care Provider Name ____

Address ____

____

Phone: ______________________________ Fax: ____________________________

____ _____________
Signature of Health Care Provider/Physician/APRN Date