Medical Excuse Form

This form is required ONLY after five (5) medically excused absences (doctor's notes) have been used. Please fax the completed Medical Excuse Form to the student's school.

SECTION I: TO BE COMPLETED BY PARENT/GUARDIAN

Student Name _____ Date of Birth _____ School Name _____

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

_____ _____
Parent/Guardian Signature **Date**

SECTION II: TO BE COMPLETED BY A MEDICAL PROVIDER

Date of Appointment _____ Time of Appointment _____ Time In _____ Time Out _____

Reason of Appointment (check only one)

☐ Current Injury/Illness ☐ Routine Office Visit ☐ Follow-up Visit ☐ Orthodontic
☐ Dental ☐ Vision ☐ Emergency ☐ Tests
☐ Other _____

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

Will this student need to be absent more than one day? Yes _____ No_____

If Yes, how long? _____ When may this student return to school ? _____ (date)

Health Care Provider _____ _____
Signature **Date**

Name & Address _____ Phone _____

_____ Fax _____