CALLOWAY COUNTY SCHOOLS MEDICAL EXCUSE FORM

This form is required ONLY after ten (10) regular medically excused absence events.

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 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 more than five (5) days, the parent should please contact the board office to request an application for home hospital placement.

This student may return to school on: _____ (Date)

Health Care Provider Printed Name: _____

Address: _____

Phone: _____

_____ _____

Signature of Health Care Provider/Physician/APRN **Date**

(Adopted 07/14/2016)