

Medical Excuse Form

Student Information (completed by parent/guardian)

Student Name: _____

Date of Appointment: _____ Time of Appointment: _____

Reason for Appointment: _____

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

Parent or Guardian Signature

The following is to be completed by a Medical Professional:

The above named student has exhausted his/her use of health care provider's notes (10 per year) for this school year. As a result, Breathitt County Schools requires medical verification for the following information.

Time In: _____ Time Out: _____

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

Yes No Comments: _____

Was it necessary for the student to have missed all day due to office location, illness, nature of treatment, etc.? Yes No

Will this student need to be absent more than one day? Yes No

If Yes, how long? _____

(NOTE: If this student will be out for more than five (5) consecutive school 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: _____

Date: _____

Adopted/Amended: 06/24/2014
Order #: