Medical Excuse Form
Gallatin County Schools

75 Boardwalk
Warsaw, Kentucky 41095
Phone 859-567-1820 / Fax 859-567-4528

(This form required only after 10 regular 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

IMPORTANT NOTE: The above child has missed ten (10) or more school days already this year due to medical absences. In order to keep our students in school as much as possible and ensure a quality education for our students, we ask that the doctor or ARNP complete this form and return it to the school with the student. A regular excuse will not be accepted for this student due to excessive medical absences that have already occurred.

Date of Appointment_____

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

Reason for Appointment **(i.e. routine office visit, follow up visit, orthodontist, dentist, emergency, tests)**

_____

_____

Was it medically necessary for this student to be absent on the date of appointment?
Yes ___ **No**___ **Comments**_____

If no, would student have missed all day due to office location, etc.? Yes ___ **No** ___

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

If yes, how long? _____
(If this student will be out for six days or longer, please complete a Home Hospital application.)

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

Health Care Provider: _____
Name & Address:

_____

_____

Phone_____ **Fax** _____

Signature of Physician/ARNP _____

Date _____

Return this completed form to the School Attendance Leader.