Franklin COUNTY SCHOOLS

STUDENT MEDICAL ABSENCE

<u>To be completed by Medical Provider</u>
The appointment is subject to be verified by the school staff.

Student's Name: _____

Medical Provider: _____
(Medical Provider)

_____ _____
(Medical Provider's Mailing/Street Address) *(Medical Provider's Telephone Number)*

_____ _____
(City) *(State)* *(Zip)* *(Medical Provider's Fax Number)*

Date of Service: _____

The above-named patient/student was seen in our office/facility at _____a.m./p.m. and was discharged at _____a.m./p.m.

This student may return to school/work: ☐ Today

☐ Other - Date/Time/Instructions: _____

_____

_____

Restrictions: ☐ None

☐ _____

_____

Signed: _____ _____
(Medical Provider/Staff) *(Date)*

Verification by _____***School***

Received by _____ Date_____

☐ Excused Absence: _____
(Class Periods/Day)

☐ Unexcused Absence: _____