Russell County School District
Medical Excuse Form

SCHOOL PHONE NUMBERS

Jamestown Elementary (270)343-3966
Russell County High School (270)866-3341
Russell County Middle School (270)866-2224
Russell Springs Elementary (270)866-3587
Salem Elementary (270)866-6197

SCHOOL FAX NUMBERS

Jamestown Elementary (270)343-3350
Russell County High School (270)866-8830
Russell County Middle School (270)866-8679
Russell Springs Elementary (270)866-7456
Salem Elementary (270)866-3687

This form is required ONLY after ten (10) medically excused absences (doctor's notes) or tardies (doctor's note) or any combination of medically excused absences or tardies equaling ten(10). Please fax the completed Medical Excuse Form to the school fax number listed above.

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 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 _____

Comments: _____

Was it necessary for the student to be absent from school for an entire day? Yes _____ No _____

If no, would student have missed all day due to office location? Yes _____ No _____

Comments: _____

Could this appointment have been scheduled during non-school hours? 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)

If this student is to be absent five (5) consecutive days or more, please complete a Home/Hospital application. Please call Russell County Board of Education at (270)343-3191 to have an application faxed.

Health Care Provider _____ _____
Signature ***Date***

Name & Address _____ **Phone** _____

(Please Print) _____ **Fax** _____