Mercer County Truancy Prevention Forms

This form is required ONLY after ten (10) medically excused absences or tardies or for reoccurring appointments. This form needs to be completed and turned in on the day of the student's return to school along with the doctor's note. There is a 5-day grace period to submit the documentation, after five (5) days, it will be counted as unexcused.

PARENTS (STUDENTS) – PLEASE TAKE THE STUDENT'S ATTENDANCE PROFILE TO THE DOCTOR WITH YOU SO IT MAY ASSIST THE PHYSICIAN IN DETERMINING HOW MUCH THE ILLNESS & RELATED ABSENCES ARE IMPACTING THE CHILD'S REGULAR ATTENDANCE IN SCHOOL

Student Name: ____

Release of Information: I hereby authorize this health care provider to release the information requested on this form for my child listed above. I understand that this is a reciprocal release between the medical/mental health care provider listed below and Mercer County School employees to share educational information regarding school services (special educational services, 504 plans, G/T records, psychological testing, counseling issues, etc.), absences, grades, behavior, and medical information that are related to school absences in the hopes of preventing chronic absenteeism and improving school attendance. The information shared between the school and medical health care provider will remain confidential between the two parties unless the information is pertinent to the student's educational services, the safety of the student listed, or others.

____ _____________

Parent Signature **Date**

If a student is to be absent five or more consecutive days, please complete a homebound application.

Date of Appointment: ____________ Time of Appointment In: ________ Time Out: _______

Is this student regularly seen in your office? □ Yes □ No

Reason for Appointment (check only one) □ Routine Office Visit □ Follow-up/Re-occurring Visit
□ Orthodontic □ Dental □ Vision □ Emergency □ Tests

Was it medically necessary for this student to be absent the entire day of appointment? □ Yes □ No

If not, would the student have to miss all day due to office location, etc.? □ Yes □ No

Date student may return to school: _______________________

Did the student /parent bring the students' attendance profile for you to review?_____

If so, please initial the attendance profile form.

Will the student have recurring follow-up appointments in your office (ex: weekly counseling visits, monthly orthodontist visits, etc.)? □ Yes □ No

If yes, how frequently and when?____

*Parents: Please schedule recurring appointments after school hours, if possible.

Health Care Provider Name ____

Address:____**Phone:**_______________________

_______________________________________ ______________

Health Care Provider **Date**

____ ______________

Principal Review & Signature **Date**