MEDICAL ABSENCE FORM

Student Name: ____

Date of Visit: ____________________ Age: __________ D.O.B: ______________

Parent/Guardian: ____

Hospital/Clinic/ER: ____

Physician: ____

Reason for Visit: ____

Diagnosis: ____

Physician Recommendations: ____

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Limitations (if applicable): ____

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Signature of Physician: ______________________________ Date: ______________