

**TYRONE AREA SCHOOL DISTRICT
MEDICAL EXCUSE FORM**

Student Name _____ Grade _____ Date of Birth _____

I hereby authorize this health care provider to release the information requested on this form only for my child listed above. The purpose of this section is to ensure your child's educational needs are being met.

Parent Signature: _____ Date: _____

Date of Appointment _____

Time of Appointment _____ Time In _____ Time Out _____

Reason for Appointment (check only one)

☐ Current Illness/Injury ☐ Office Visit ☐ Follow-up Visit Orthodontic
☐ Dental ☐ Vision ☐ Emergency Tests ☐ Other _____

Was it medically necessary for this student to be absent on date of appointment? Yes ____ No ____
Comments:

Was it necessary for the student to be absent from school for an entire day? 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)

Physician's Name _____

Address _____

Telephone _____

Physician's Signature _____