Franklin County Schools

Our Future, Our Commitment, Our Students

STUDENT MEDICAL ABSENCE

To be completed by Medical Provider
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: _____