

School Absence

Patient's Name: _____

Appointment Information

Date: _____ Time: _____

The above named student/patient was seen in this office by the:

Physician
Physician's Asst.

☐ ☐ Nurse
☐ ☐ Office Staff
☐ ☐ Other

Nurse Practitioner

Patient May Return to School:

- ☐ Today
- ☐ Tomorrow
- ☐ On _____

Day

Date

Physician Name: _____

Address: _____

Physician's Signature : _____