Medical Use Form

Student Information *(completed by parent/guardian)*

Student Name: _____

Date of Appointment: _____ Time of Appointment: _____

Reason for Appointment: _____

_____

I hereby authorize this health care provider to release the information requested on this form for my child listed above:

_____
Parent or Guardian Signature

The following is to be completed by a Medical Professional:

The above named student has exhausted his/her use of ten (10) doctor notes for this school year. As a result, Lincoln County Schools requires medical verification for the following information.

Time In: _____ Time Out: _____

Was it medically necessary for this student to be absent on date of appointment?

☐ Yes ☐ No Comments: _____

Was it necessary for the student to have missed ***all day*** due to office location, illness, nature of treatment, etc.? ☐Yes ☐No

Will this student need to be absent more than one day? ☐Yes ☐No

If Yes, how long? _____
(NOTE: If this student will be out for more than five (5) consecutive school days, please ask the parent to bring you a home hospital application to complete.)

This student may return to school on _____
Date

HEALTH CARE PROVIDER

Name & Address: _____

_____

_____

_____

Phone: _____ Fax: _____

Signature of Physician/APRN: _____

Date: _____

Review/Revised:12/10/2015