Medical Evidence Requirement Excuse Form

Homer-Center High School

70 Wildcat Lane, Homer City PA 15748
Phone 724-479-8026 Fax 724-479-4236

(This form is required for students on Medical Evidence Requirement)

Student Name_____ Date of Birth_____

I hereby authorize this health care provider to release the information requested on this form for my child listed above. _____
Parent or Guardian signature

Date of Appointment_____

Time of Appointment _____ Time In _____ Time Out _____

Reason for Appointment (i.e. routine office visit, follow up visit, orthodontist, dentist, emergency, tests)

_____

_____

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

Yes ___ No___ Comments_____

If no, would student have missed all day due to office location, etc.? Yes ___ No ___

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

If yes, how long? _____
(If this student will be out for ten days or longer, please complete a homebound application.)

This student may return to school on _____ Date

Health Care Provider Name _____

Address _____

Phone _____ Fax _____

Signature of Physician/ARNP/PA _____

Date _____