Union Country School System

School Absence

Patient's Name: ______________________________

Appointment Information

Date: _______________________ Time: _________________________

The above named Student / Patient was seen in this office by the:

- ☐ Physician
- ☐ Nurse
- ☐ Physician's Asst.
- ☐ Office Staff
- ☐ Nurse Practitioner
- ☐ Other

Patient May Return to School:

- ☐ Today
- ☐ Tomorrow
- ☐ On _______________________ __________________________

Day Date

Physicians Name: _____________________________________

Address:

____

Physician's Signature: _________________________