



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: _____