

# Union County School System School Absence

Patient's Name: \_\_\_\_\_

## Appointment Information

Date: \_\_\_\_\_ Time: \_\_\_\_\_

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

- |   |                                       |
|---|---------------------------------------|
| <input type="checkbox"/> Physician          | <input type="checkbox"/> Nurse        |
| <input type="checkbox"/> Physician's Asst.  | <input type="checkbox"/> Office Staff |
| <input type="checkbox"/> Nurse Practitioner | <input type="checkbox"/> Other        |

Patient May Return to School:

Today

Tomorrow

On \_\_\_\_\_  
Day Day

Physician Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

**Physician's Signature:** \_\_\_\_\_

Revised 8/1/2010