# Student Absence Authorization

|  |  |
| --- | --- |
| Patient’s Name: |  |

Appointment Information

|  |  |  |  |
| --- | --- | --- | --- |
| Date: |  | Time: |  |

This is to certify that the above-named Student / Patient was seen in our office by the:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Physician |  | Nurse |  | Physician’s Asst. |
|  |
|  | Office Staff |  | Nurse Practitioner |  | Other |

Patient May Return to School:

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Today |  | Tomorrow |  | On |  |  |  |
|  | *(Day)* |  | *(Date)* |

|  |  |
| --- | --- |
| Physician’s Name: |  |
| Address: |  |
|  |  |

|  |  |
| --- | --- |
| Physician’s Signature |  |