STUDENT NAME / *NOMBRE DEL ESTUDIANTE*: _____

SCHOOL / *ESCUELA*: _____

DOB / *FECHA DE NACIMIENTO*: _____

Notice to Attending Physician / *Aviso para el médico tratante*

Due to excessive absences from school that exceed state guidelines, the student above must be seen by a physician in order for the absences to be excused. Absences will only be excused if a physician orders the student not to be in school or a school nurse determines the student should not remain in school due to illness. **This form** must be fully completed and signed by the physician. The student is to return it to the attendance office or the school nurse within **24 hours** of returning to school after an absence.

Debido a las ausencias excesivas de la escuela que superan las pautas estatales, el estudiante mencionado anteriormente debe ser visto por un médico para que se justifiquen las ausencias. Las ausencias solo se justificarán si un médico ordena que el estudiante no asista a la escuela o si una enfermera escolar determina que el estudiante no debe permanecer en la escuela debido a una enfermedad. ***Este formulario*** *debe ser completado en su totalidad y firmado por el médico. El estudiante debe devolverlo a la oficina de control de asistencia o a la enfermera de la escuela dentro de las* ***24 horas*** *posteriores a su regreso a la escuela después de una ausencia.*

Without this form completed in its entirety, the absence/tardy will be recorded as **unexcused/truant.**

Sin este formulario completado en su totalidad, la ausencia/tardanza se registrará como ***injustificada.***

Sincerely / *Atentamente*,

District 308 Student Services / *Servicios Estudiantiles del Distrito 308*

Date the student was examined: _____ Time In: _____ Time Out: _____

List the date(s), if any, that it was determined medically necessary for the student to be excused from school as a result of the examination. Please include specific dates below:

The student is able to return to school _____ Yes _____ No

School may call your office if there are questions _____ Yes _____ No

Medical facility name: _____

Medical facility address: _____

Physician's full name (printed): _____

Physician's signature: _____

Physician's medical stamp: