

SCHOOL NAME: _____ DATE: _____

STUDENT NAME: _____ GRADE: _____

IS RETURNING TO SCHOOL AFTER AN ABSENCE OF _____ DAYS

DUE TO: _____

PLEASE CIRCLE ALL THAT APPLY IF ABSENCE IS RELATED TO ILLNESS:

COUGH SORE THROAT RUNNY NOSE RASH HEADACHE
FEVER/TEMP _____°F NAUSEA VOMITING DIARRHEA STOMACH PAIN
OTHER: _____ MY CHILD WAS SEEN BY A HEALTH CARE PROVIDER

PARENT/GUARDIAN NAME

PARENT/GUARDIAN SIGNATURE

✂ *****

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