# STUDENTS 09.123 AP.2

Absentee Forms

Educational Enhancement Opportunity Request Form

To request an absence to attend or participate in an educational activity, please complete this application form and return it to your school principal ~~at least five (5) days prior to the absence~~. Such an absence as requested by this signed application and approved by the school principal, will be considered an excused absence if received within 5 days of the absence occurring. The major intent of the activity must be educational in order for the student to be granted this type of absence. The proposed activity must have significant educational value and be composed of an intensive program related to the core curriculum (e.g. art programs, dance programs, State Fair activities, workshops that are educational in nature, college visits, etc.). The Principal will use his/her good judgment to determine if the activity meets guidelines. A student may be approved for up to ten (10) days of absence per year for this purpose. Students who are granted an absence under this law will be allowed to make up all school work. Student grades cannot be affected by lack of attendance or participation in classes for approved days. **This type of absence cannot occur during the school’s state assessment or District-wide assessments, unless there are extenuating circumstances that are approved by the Principal.** Decisions may be appealed to the Superintendent and then to the Board of Education.

Student Full Legal Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Application\_\_\_\_\_\_\_\_\_\_\_

Name of School \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Homeroom Teacher\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_ Grade Level: \_\_\_\_\_\_\_\_Home Phone\_\_\_\_\_\_\_\_

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

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_

# \_\_\_\_\_\_\_\_of Excused Absences To Date\_\_\_\_\_\_ # of Unexcused Absences To Date\_\_\_\_\_

# of Total Absences to Date\_\_\_\_\_\_

Date(s) of Intended Absence(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please explain the nature of the event the student will be attending and how the activity meets the criteria of (1) having an educational purpose, (2) having “significant educational value,” and (3) how the activity is directly related to one of the core curriculum subjects of English, science, mathematics, social studies, foreign language or the arts. Please attach a schedule of activities/events to be attended. (Use additional paper, if needed, and attach to this completed form.)

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***Signature of Student Date Signature of Parent/Guardian Date***

STUDENTS 09.123 AP.2

 (Continued)

Absentee Forms

Educational Enhancement Opportunity Request Form

FOR SCHOOL USE ONLY

(THIS SECTION TO BE COMPLETED BY THE SCHOOL PRINCIPAL / DESIGNEE)

This request must meet all three criteria to be eligible for an educational opportunity absence:

1. This request is for an absence that will have “significant educational value” and be “intensive” in nature. Yes 🞏 No 🞏
2. This trip is tied to one of the core curriculum subjects of English, science, mathematics, social studies, foreign language or the arts. Yes 🞏 No 🞏
3. The major purpose of the trip is educational. Yes 🞏 No 🞏

As Principal, I recommend 🞏 I do not recommend 🞏 that this educational opportunity absence be granted.

Principal’s Rationale \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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***Signature of Principal Date***

### FOR CENTRAL OFFICE USE

As Superintendent, I approve 🞏 I do not approve 🞏 that this educational opportunity absence be granted.

Superintendent’s Rationale\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 ***Signature of Superintendent Date***

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 (Continued)

Absentee Forms

Mercer County Attendance/Truancy Prevention

Medical Excuse Form

**Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

This form is required ONLY after ten (10) medically excused absences or tardies. This form needs to be completed and turned in on the day of the student’s return to school. There is a 5 day grace period to submit the documentation, but after five (5) days, it will be counted as unexcused. PARENTS (STUDENTS) – Please take the students attendance profile to the Doctor for them toreview. It may assist the Physician in determining how much the illness and related absences are impacting the child’s regular attendance in school**.**

**Release of Information**: I hereby authorize this health care provider to release the information requested on this form for my child listed above. I understand that this is a reciprocal release between the medical health care provider listed below and Mercer County School employees to share educational information regarding school services (special educational services, 504 plans, G/T records, psychological testing, counseling issues, etc.), absences, grades, behavior, and medical information that are related to school absences in the hopes of preventing chronic absenteeism and improving school attendance. The information shared between the school and medical health care provider will remain confidential between the two parties unless information is pertinent to the student’s educational services, or the safety of the student listed or others.

\*Parents: Please schedule reoccurring appointments after school hours. If this is not possible, please make the school aware of the dates/times of appointments and we may be able to adjust your child’s schedule to minimize the effect on their learning.

**Parent or Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­

**INFORMATION BELOW TO BE COMPLETED BY THE HEALTH CARE PROVIDER:**

**\*If student is to be absent five (5) or more consecutive days, please consider and complete a homebound application.**

Date of Appointment:\_\_\_\_\_\_\_\_\_\_\_\_Time of Appointment: \_\_\_\_\_\_\_\_ Time In: \_\_\_\_\_\_ Time Out: \_\_\_\_\_\_\_\_

Reason for Appointment (check only one) 🞏 Routine Office Visit 🞏 Follow-up Visit 🞏 Orthodontic 🞏 Dental

🞏 Vision 🞏 Emergency 🞏 Tests ❑Other

Was it medically necessary for this student to be absent the entire day on date of appointment? 🞏 Yes 🞏 No

If no, would student have missed all day due to office location, etc.? 🞏 Yes 🞏 No

Date student may return to school: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did the student/parent bring the students’ attendance profile for you to review? 🞏 Yes 🞏 No

(Please initial the information you reviewed)

Will the student have reoccurring follow-up appointments in your office 🞏 Yes 🞏 No

(ex.: weekly counseling visits, monthly orthodontist visits, etc.)

If yes, how frequently and when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Health Care Provider/Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Health Care Provider/Physician/ARNP Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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Principal Review & Signature Comments Date

 Review/Revised:9/19/2019