Chronic Illness/Ongoing Treatment Medical and Excuse Forms

Medical Release Form (MRF)

Student Name: _____

I hereby authorize this health care provider to release the information requested on this form for my child listed above. _____ _____
Parent Signature Date

Date of Appointment: _____Time of Appointment: _____ Time In: _____ Time Out: _____

Reason for Appointment (i.e. routine office visit, follow-up visit, orthodontic, dentist, emergency tests, etc.) _____

Was it medically necessary for this student to be absent on date of appointment? YES NO

Could this appointment have been scheduled during non-school hours? YES NO

Will student need to be absent more than one (1) day? YES NO

If yes, how long? _____ This student may return to school on _____ (date)

School Board Policy allows for five (5) parent notes and ten (10) doctor's notes per school calendar year prior to use of Chronic Illness/Ongoing Treatment Medical Excuse Form. This form is to allow additional days as determined by a professional health care provider.

If student is absent five (5) consecutive days or longer, please consider a homebound application. Call 859-292-3001.

Health Care Provider _____ _____
Signature Date
Name & Address _____ Phone _____
Please Print _____ Fax _____

Newport Independent School District complies with the Health Insurance Portability and Accountability Act (HIPPA).

☐ **APPROVED** ☐ **DENIED** _____ _____
School Principal or Director of Pupil Personnel **Date**

Medical and Excuse Forms

Health Care Professional Excuse Form
Standing Excused Doctors Note (SEDN)

Student Name: _____

CHRONIC MEDICAL NEEDS

This student has chronic needs. Please allow for the following accommodations: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

How many times a student may miss on own without attending a medical facility due to this illness: _____

School Board Policy allows for five (5) parent notes and ten (10) doctor's notes per school calendar year. Will this student need additional days? ☐ Yes ☐ No

If this student is absent five (5) consecutive days or longer, please consider a homebound application. Call 859-292-3001.

Health Care Provider Signature _____ **Date** _____

(Please print)
Name/Address _____ **Phone** _____

_____ **Fax** _____

☐ **APPROVED** ☐ **DENIED** _____ _____
School Principal/ Director of Pupil Personnel **Date**

Newport Independent School District complies with the Health Insurance Portability and Accountability Act (HIPPA).