Bishop Moore Catholic
HIGH SCHOOL

MEDICAL ABSENCE VERIFICATION FORM

Bishop Moore Catholic High School is requesting the following health-related information to verify this student's extended medically-related absence from school. The form below is to be completed by your student's physician, physician's assistant, or nurse practitioner and submitted to the Attendance Office with attached supporting documentation.

Form Completion Date: __ / __ / __

Part 1. Student Information

Student's Name: _____ Sex: _____ Age: _____ Date of Birth: __ / __ / __

Name of Parent/Guardian:_____ E-Mail: _____

Part 2. Physician Information

To be completed by licensed physician, licensed physician assistant or certified advanced registered nurse practitioner.

Personal/Family Physician: _____ City/State: _____ Office Phone: (____) _____

Date(s) of medically-related school attendance impact: _____

General Assessment:

_____ Cleared for regular school participation/attendance without limitation

_____ NOT Cleared for regular school participation/attendance

_____Cleared for school participation/attendance with limitations that are specified below

Notes for the school:

_____

_____

_____

_____

I hereby certify that the examination(s) for which referred was/were performed by myself or an individual under my direct supervision:

_____ _____

Signature of Physician/Physician Assistant/Nurse Practitioner Date

Part 3. Parent/Guardian Signature

I understand that should my student's condition change it is my responsibility to notify the school immediately and resubmit an updated Medical Absence Verification form, with appropriate supporting documentation. I understand that my student is responsible for following all Bishop Moore Catholic High School Attendance policies as stated in the Student Handbook.

_____ _____

Parent/Guardian Signature Date

Rev: August 14, 2024