

ABSENCE FROM SCHOOL TO ATTEND A MEDICAL APPOINTMENT

Pupil Details
Name
Class Teacher/Class
Appointment (Doctor/Dentist/Hospital/Specialist)
Date:
Time:
At:
I will be collecting my child/children from School at:
I hope to return my child/children to School by:
Proof of appointment seen by:
Name of Parent/Carer:
Signature:
Date:
Contact Number:
Only under special circumstances are we able to 'authorise' more than half a school day for an appointment. If you feel the appointment will require more than half a day, please detail the reasons why here:

Unless you are advised otherwise this appointment request will be authorised.
Thank you for providing this information.