|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Student Sick Slip  Company Name-Address Your Location Here-Email at [Youremailaddress@email.com](mailto:Youremailaddress@email.com)-Phone: 090012345678 | | | | | | | | | | |
|  | | | | | | | | | | |
| **Patient’s Information:** | | | | | | | | | | |
| Full Name: | |  | | | Date of Birth: | | | |  | |
| Address: | |  | | | Contact Number: | | | |  | |
|  | | | | | | | | | | |
| **Medical Facility Information:** | | | | | | | | | | |
| Facility Name: | | |  | | | License Number: | | |  | |
| Doctor’s Full Name: | | |  | | | Contact Number: | | |  | |
| Facility Address: | | |  | | | | | | | |
|  | | | | | | | | | | |
| **Absence Duration:** | | | | | | | | | | |
| First Day of Absence: | | | | Expected Return Date: | | | | Total Days Absent: | | |
|  | | | |  | | | |  | | |
|  | | | | | | | | | | |
| **Medical Details:** | | | | | | | | | | |
| Diagnosis / Reason for Absence: | | | | | | | | | | |
|  | | | | | | | | | | |
|  | | | | | | | | | | |
| Special Instructions / Recommendations (if any): | | | | | | | | | | |
|  | | | | | | | | | | |
|  | | | | | | | | | | |
| **Medications Prescribed (if any):** | | | | | | | | | | |
| Medication Name: | | |  | | | | | | | |
| Dosage: | | |  | | | | | | | |
| Duration: | | |  | | | | | | | |
| **(Repeat as necessary for additional information or recommendations)** | | | | | | | | | | |
| Additional Notes (if any): | | | | | | | | | | |
|  | | | | | | | | | | |
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|  | | | | | | | | | | |
| **Certification:** | | | | | | | | | | |
| I hereby certify that the above-named student is under my care and was found to be medically unfit for school attendance during the specified dates. | | | | | | | | | | |
| Signature: |  | | | | | | Date: | | |  |