Saint Paul's Catholic High School

Medical Evidence Form

Date: _____

Name: _____

I confirm that the above named attended an appointment with

GP ☐ **Dentist/Orthodontist** ☐ **Hospital** ☐ **Other** ☐ **(please state)** _____

Date: _____ **Time Arrived:** _____ **Time Left:** _____

The above named pupil is required to refrain from school: YES ☐ **NO** ☐

If they are required to refrain from school, please state how long for:

_____

Practitioner's Stamp:

Should you have any questions about the use of this form, please contact a member of the Attendance Team on the number below.

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