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**THE PATIENT WHOSE NAME APPEARS ON THE OTHER SIDE:**

Was seen in clinic on the date shown \_\_\_\_\_

Should not work or attend school from \_\_\_\_\_ to \_\_\_\_\_

Should be excused from Phys. Ed. from \_\_\_\_\_ to \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Name (*Print*)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Area Code & Phone #