

**MEDICAL REQUEST LEAVE OF ABSENCE FORM**

Name of Pupil………………………………………………………………..……….Class………………………………….………………

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| **Date of Appointment** | **Time of Appointment** | **Dentist** | **Doctor** | **Optical** | **Hospital** |
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Parents signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



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