

Vernon Hills High School Medical Excuse

Name of Student:	Date of Birth
First Day Out of School Due to Illness:	
Return Date:	
Diagnosis:	
Accommodations:	
Physician's Name:	
Address:	Phone #:
Physician Signature:	Date:
I hereby authorize the release of medical information to the individuals who are affiliated with Community District #128.	
Parent Signature:	Date:
Vannan Hilla High Cahaal 445 N. Lakasiasu Dadusas	Variation IIII III 00004 047 000 0000