

**LEAVING SCHOOL DURING SCHOOL DAY**  
**2026-27**

Please attach proof of medical/dental appointment to this form

|                      |                                  |
|----------------------|----------------------------------|
| Name of child:       |                                  |
| Class:               |                                  |
| Date:                |                                  |
| Time leaving school: |                                  |
| Returning same day?  | YES / NO (delete as appropriate) |
| Reason:              |                                  |

Parent's signature: \_\_\_\_\_

Date: \_\_\_\_\_

