



WITLEY C. OF E. INFANT SCHOOL
REQUEST FOR PART OR DAY ABSENCES (MEDICAL APPOINTMENTS)

Name of child..... Class.....

I/We request authorisation for school absence

From (TIME) To (TIME) Date.....

For the following reason: (please specify).....
.....

Signature of Parent/Guardian..... Date.....

ABSENCE AUTHORISED:	Yes/No
REASON (IF NOT AUTHORISED):
HEADTEACHER'S SIGNATURE

Please note the routine dental check ups should be arranged out of school hours or during the school holidays.