Holly Area Schools

Discontinued Treatment Form

Student's Name: _____ School Year: _____

Date of Birth: _____ School/Program: _____

Age: _____ Grade: _____ Medical Alert to be Removed: _____

Parent/Guardian:

You previously notified Holly Area Schools that your student has a medical condition documented by an authorized medical provider and notated in their school records. If your student is currently continuing with their medical treatment, please have appropriate school medical forms filled out by their provider and returned to the school office. If your student no longer requires treatment, the medical provider must sign the statement below and this form must be returned to the school office in order to have that notice removed from your student's school record.

The following student, _____ at

Holly Area Schools is no longer under my professional care for _____

(example: seizures, asthma) and does not require medical documentation or notification in the

school alert system.

Physician/Authorized Prescriber: (Print)_____

Phone Number: _____ Fax Number:_____

Signature: _____ Date: _____

Parent Signature: _____ Date: _____