

Statement of Chronic Illness Form

Dear Parent/Guardian:

This form must be completed by your child's physician/health care professional and given to the school each school year. This statement will be used for attendance appeal purposes if your student exceeds the allowable number of days for his/her grade level according to the 90% attendance rule. The Attendance Appeal Committee reviews each chronic illness form at attendance appeal time and grants an appeal based on the health care professional's statements written below.

Students Name: _____

Date of Birth: _____ Campus: _____

The student named above suffers from a chronic illness and may have to miss school. The chronic illness may or may not require a visit to the doctor.

Chronic condition: (please describe in specific terms the student's chronic medical condition).

1. Does the student need to miss more than 9 days per semester due to the chronic illness?

Yes () No () Comments: _____

2. Does the student need to see the health care provider if he/she misses school due to the chronic condition?

Yes () No ()

3. How many days per semester do you anticipate the student needing to miss due to this condition? _____

Doctor's/Health Care Professional's Name: _____

Address: _____

Phone number: _____ Fax number: _____

Physician signature: _____ Date: _____

By signing this form, you understand that you give permission for the school nurse to contact the physician if she has questions regarding the chronic condition outlined above. Please be advised that a completed chronic illness form signed by the treating health care provider will cover only excused absences in relation to the chronic condition. To excuse the absence, the parent/guardian must send a written note that is received in the attendance office no later than 3 days after the absence has occurred.

Parent signature: _____ Date: _____