

# CHRONIC AILMENT PHYSICIAN'S STATEMENT OF ILLNESS

STUDENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

This student is a patient of mine and has been diagnosed with the condition outlined below. This condition may necessitate absences from school. **THIS STATEMENT MUST BE SUBMITTED TO YOUR CHILD'S SCHOOL AT THE BEGINNING OF THE FIRST SEMESTER also UPDATED AND RESUBMITTED AT THE BEGINNING OF SECOND SEMESTER.**

Diagnosis:

Anticipated number of absences:

Requirement for returning to the physician's office:

Physical limitations the student may have in getting to school:

Other pertinent information related to this illness:

Doctor's name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

\_\_\_\_\_

Physician's Signature (**REQUIRED**)

Date