# 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