Health Services

CHRONIC CONDITION STATEMENT

STUDENT NAME: _____ SCHOOL YEAR: _____

SCHOOL: _____GRADE: _____DOB: _____

TO BE COMPLETED BY THE HEALTHCARE PROVIDER
(physician, physician assistant, or nurse practitioner)

This student is my patient and has been diagnosed with the chronic condition listed below. This chronic condition may necessitate absences from school.

Medical Diagnosis / Chronic Condition: _____ ICD-10 Code: _____

Anticipated Number of Absences:
*(There are approximately **90** instructional days each semester.)*

Fall Semester: _____ possible days absent	Spring Semester: _____ possible days absent
A visit to my office / clinic is required if student is out of school for _____ consecutive days.	

Comments: _____

_____

Provider Name (Print): _____Telephone Number: _____

Address: _____ City: _____State: _____ Zip: _____

Provider Signature: _____Date: _____

I am aware when my child is absent from school due to the above chronic condition. When absent due to the above chronic condition, I will provide a parent excuse (note) referencing this form, which will be kept on file in the school office. I understand that absences unrelated to the above-mentioned chronic condition may not be excused. I understand that a new *Chronic Condition Statement* form is required each academic year.

Parent/Guardian Signature:_____ Date: _____