BROOKE COUNTY SCHOOLS
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Chronic Health Condition Statement

•This form must be updated and completed in its entirety each semester and will only excuse days after the receipt of the form.

A student's regular attendance at school is crucial to optimal learning. Learning opportunities that occur in the classroom are meaningful and essential components of the learning process. Time lost due to chronic absences from school is irretrievable in terms of opportunity for instructional interaction. Research tells us that missing as little as two days per month makes the child less likely to graduate.
Brooke County Schools is requesting that you verify that this student has a chronic health condition that may impact regular attendance at school. Please note that this document becomes part of the student's educational file and the educational file may be presented, if requested, should the student become truant and need to go before the court system.
This document is not an excuse from completing required class assignments due to absences.

Students Name: _____DOB: _____

School: _____ Grade: _____

Physicians Printed Name: _____

Physician Address: _____

Physician Phone: _____ Physician Fax: _____

Diagnosis: _____

Approximate # of days per month this condition may keep the child from attending school: **
If the number of absences exceeds this number, the absences will be counted as unexcused and the medical provider should be notified by the parent to ensure the child's health need is being met.

Physician Signature: _____Date: _____

I, the parent/guardian of the above named student, grant permission for Brooke County Schools to obtain and release information regarding my son/daughter from the department, agency, or licensed medical provider identified above. I also hereby release the named department, agency, or licensed medical provider from legal liability that may arise from further disclosure of said records.

In addition, I understand that I must send a note referring to the chronic health form in order for the absences to be marked as excused. *I also understand that it is my child's responsibility to obtain and complete all missed school work resulting from these absences.*

Parent/Guardian Name: _____ Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Parent/Guardian Signature: _____ Date: _____

** **If the amount recommended is more than 2 days per month, the SAT, 504, or IEP team should convene to review interventions and services that will support learning. A medical release may be requested for team determination of interventions/health care supports at school.**