PHYSICIAN'S CERTIFICATION OF SERIOUS OR LIFE-THREATENING ILLNESS

To be completed by a licensed physician

Patient Name (Student): _____

Date of Birth: _____

Physician's Name: _____

Medical License Number: _____

Phone Number: _____ Fax: _____

Practice Address: _____

_____

1. Specific Illness Diagnosis

(Please specify the medical condition affecting the student.)

_____

_____

2. Severity of Illness

☐ I certify that the above-named student is suffering from a serious illness.

☐ I certify that the above-named student is suffering from a life-threatening illness.

Brief explanation (optional):

_____

_____

3. Anticipated Period of Absence from School

Start Date: _____

End Date (if known): _____

☐ Duration is currently unknown and will be re-evaluated on: _____

4. Explanation of Infeasibility of Attendance

(Why is the student unable to attend school during the stated period?)

_____

_____

_____

Physician's Certification

I hereby certify that the information provided above is accurate and based on my professional evaluation of the student's condition.

Physician Signature: _____

Date: _____

Return completed form to the front office of your child's school.

NOTE TO OFFICE STAFF:
Please make sure the campus principal, school nurse, and attendance clerk receives a copy of this form.