Chronic Health Condition
School Attendance Plan

Student _____ DOB _____ School _____ GR _____

Parent _____ Home # _____ Work # _____ Cell # _____

Physician _____ Office # _____

I authorize the school system to contact my child's physician, clinical psychologist, psychiatrist, or nurse practitioner and I authorize them to share information with the school division concerning my child's need for a chronic health plan.

_____ _____
Signature of Parent Date

To be completed by administrator prior to sending form home.

Number of days absent _____ Number of days school in session _____

Health Information (To Be Completed By Physician):

Medical Diagnosis that prevents student from attending school.
_____

Explain why this chronic health condition may result in excessive absences from school. _____
_____
_____
_____
_____
_____
_____

Physician Signature _____ **Date** _____

School Attendance Plan (To Be Completed By Administrator): _____
_____
_____
_____
_____
_____
_____

_____ _____
Principal Date

_____ _____
Parent Date

R2/11