

Physician's Certificate of Student's Illness of Incapacity to Attend School**TO BE COMPLETED BY PARENT/GUARDIAN**

_____ Name of Student	_____ Student's Date of Birth (mm/dd/yyyy)
_____ Name of Parent/Guardian	_____ Student's Current Grade in School
_____ Parent e-mail	_____ Parent/Guardian Phone Number

TO BE COMPLETED BY THE PHYSICIAN

Diagnosis/description of the illness/condition that has precluded or currently precludes the student's attendance at school

Duration of the illness/condition: Permanent
 Temporary

Date (mm/dd/yyyy) student first seen by
physician for this illness/condition.

**Based on physician's diagnosis and professional
judgment, the school should expect the student's
attendance to be (please check one):**

Regular Daily Attendance
student can attend school on a regular basis

Irregular Daily Attendance
*student cannot attend school on a regular
basis and will have multiple absences without
requiring doctor visits*

Homebound Instruction
student cannot attend school at all

_____ Physician's Signature	_____ Date (mm/dd/yyyy)
_____ Physician's Printed Name	_____ Phone Number
_____ Practice Address	_____ City, State, Zip

PLEASE RETURN TO

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