MEDICAL CERTIFICATION OF CHRONIC HEALTH CONDITIONS

Student's name:

Address: City: State: Zip:

Sending School:

Grade: Date of birth:

Phone number:

Date of initial consultation: _____

Medical diagnosis:

_____
_____
_____

Medical Prognosis:

_____
_____
_____
_____

Physical limitations affecting physical education activities:

_____
_____
_____

Other relevant information:

_____
_____
_____

Anticipated number of absences due solely to illness, disease, or accident (include surgeries, treatments, or hospitalizations that may interfere with school attendance during the _____ School Year): _____ days

Type or print physician's name and licensed title:

_____

Physician's signature:_____ Date:_____

** Please turn completed form into your EVIT counselor or registration