

**Physician's Certificate of Student Illness or Incapacity to Attend School**

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
School: \_\_\_\_\_ Grade: \_\_\_\_\_

Parent Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

**To be completed and signed by the physician:**

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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Date student first seen by physician for this illness or condition: \_\_\_\_\_

Date student may be expected to return to school: \_\_\_\_\_

If unknown, please explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Date student is to return to be seen by Physician:

\_\_\_\_\_

\_\_\_\_\_  
Physician's signature

\_\_\_\_\_  
Physician's printed name

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City/State/Zip

\_\_\_\_\_  
Telephone number

\_\_\_\_\_  
Date

Please return this form to:  
**Kankakee Valley High School**  
**FAX: 219-956-4639**

If you have any questions, please call:  
**KVHS Main Office**  
**Phone: 219-956-3143 x2000**

<sup>i</sup>this certificate may be completed by an Indiana physician, an individual holding a license to practice osteopathy or chiropractic in Indiana, or a Christian Science practitioner who resides in Indiana and is listed in the Christian Science Journal. IC 20-33-2-18