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:

____
____
____

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 Middle School
FAX: 219-987-2540

If you have any questions, please call:
KVMS Main Office
Phone: 219-987-8810 x3000

[i]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