

**CERTIFICATION OF STUDENTS WITH
CHRONIC HEALTH CONDITIONS
(Obtained from a licensed health professional)**

Type or print Parent/Guardian Name

Date

Signature of Parent/Guardian

Student's name Parent's name Address

District	School	Grade level
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_____ Date of birth _____ Phone number _____ Date of initial consultation

Anticipated absences due solely to illness, disease, pregnancy complications, an accident or severe health problems of an infant child of a student (include anticipated surgeries, treatments, or hospitalizations that may interfere with school attendance during the _____ year):

Example 1: _____'s physical condition may result in frequent absences in the school year that may exceed ten (10) consecutive school days per semester, but I do not anticipate that _____ will be absent enough days to require homebound services.

Example 2: _____ will require three (3) hospitalizations of approximately four (4) days duration each and three to five (3 - 5) treatments of one (1) day each during the school year.

Other relevant information:

Type or print licensed health professional
name and licensed title

Date Licensed health professional signature and title

I authorize MUSD Nursing Staff and my health care provider to exchange information regarding my child's chronic illness.

Type or print Parent/Guardian Name

Date Signature of Parent/Guardian

OFFICE USE ONLY:

Received by: _____ Date: _____

Nurse Signature