

## BASTROP ISD PHYSICIAN CERTIFICATION FOR EXCUSED ABSENCE

*The Chronic Illness Form (CIF) allows parents to excuse absences due to a specific medical condition that is serious or life-threatening with the same authority as a medical professional, when the illness or treatment of the illness make the student's school attendance infeasible. Below are guidelines for completing the form correctly to establish and maintain this authorization.*

*This form must be completed by a physician licensed to practice medicine in Texas. School districts may not require additional documentation beyond this form ((Tex. Educ. Code §25.087(g)).*

Student Full Legal Name \*

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Campus / Grade

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Date of Birth

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Parent / Guardian Name \*

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Parent / Guardian Phone

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Parent / Guardian Email

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Dear Physician,

Your patient is a student enrolled in Bastrop ISD. For our records, please list the serious or life-threatening illness diagnosed for the student. Also, please check or list symptoms that would make the student's school attendance infeasible and the anticipated period of absence.

### Physician Certification (To be completed by the Physician)

|   |                                                                                                                                                                                                                                                                |
|---|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| A | <b>Statement of Serious or Life-Threatening Illness *</b><br>The above-named student has been diagnosed with a serious or life-threatening illness:<br>Diagnosis/Condition (description as determined by physician)<br><hr/>                                   |
| B | <b>Statement That Illness Makes Attendance Infeasible *</b><br>I certify that, as determined by me, the illness or related treatment makes the student's attendance at school infeasible during the anticipated period of absence described in item C.         |
| C | <b>Anticipated Period of Absence *</b><br>As determined by me, the estimated period during which the student's attendance is infeasible:<br>Estimated Start Date: _____ Estimated End Date: _____ Estimated Duration: _____<br>days / weeks / ongoing (circle) |
| D | <b>Additional Clinical Information (Optional - at Physician's discretion)</b><br>If clinically relevant, the physician may include any of the following. Districts may NOT require this information.<br><hr/>                                                  |

Physician Signature \*

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Date Signed \*

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Physician Name / TX Medical License Number: \*

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Practice Address / Phone Number:

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