



Chandler Unified School District
1525 W. Frye Rd
Chandler, AZ 85224

Certificate of Chronic Health Condition

School Year 20__20__

Student Name: _____ DOB: _____ Student ID #: _____

School: _____ Grade: _____

Please take this form to the **Licensed Health Professional treating the student's Chronic Condition for review**. If the provider agrees to sign the form, return it promptly to **the health office** at the school your child attends. Please make a copy for your safekeeping. The original will go into the health file of your child.

Release of Information: I authorize the Chandler Unified School District Health Staff and the Health Professional identified below to exchange information provided in this Certificate of Chronic Health Condition. It is my understanding that I must resubmit Certificate of Chronic Health Condition each school year.

Parent Printed Name

Parent Signature

Date

Health Care Provider – Please Review These Instructions Before Completing This Form

The purpose of this form is to certify the pursuant to A.R.S. § 15-346 you are the health professional who is licensed pursuant to title 32, chapter 7, 8, 13, 14, 17 or 25 or a registered nurse practitioner who is licensed pursuant to title 32, chapter 15 that is treating the above-named student for a qualifying chronic health condition.

Certification is appropriate only if the student will be unable to attend school frequently or for substantial periods due to illness, disease, injury (accident), or pregnancy complications. Certification is not appropriate if the health condition is not sufficiently debilitating to prevent the student from attending school. This form will not be retroactive.

HEALTH CARE PROVIDER – PLEASE COMPLETE THE FOLLOWING:

Diagnosed Chronic Illness or Injury: _____

Date Diagnosed: _____ Is health condition currently active? ☐ Yes ☐ No

Is the student currently able to attend school? ☐ Yes ☐ No (if No est. Date of Return _____)

☐ Yes, with accommodations _____

Is the student able to participate in physical education activities? ☐ Yes ☐ No

☐ Yes, with accommodations: _____

Will this condition cause this student to miss more than 10 days of school each semester given by law? ☐ Yes ☐ No

About how many days is the student expected to miss each semester because of this health condition? _____

*Required

By signing below, I certify, under penalty of perjury, that the foregoing is true and correct.

Licensed Health Professional Printed Name

Licensed Title

Date Signed

Licensed Health Professional Signature

Phone

Fax

Business Name and Address