

WHITNEY ISD PHYSICIAN CERTIFICATION FOR EXCUSED ABSENCE

H.B. 367 amends the Education Code to revise the conditions under which a public school district must excuse a student from attending school for an absence resulting from a serious or life-threatening illness or related treatment that makes the student's 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* _____ **Campus / Grade** _____

Date of Birth _____ **Parent / Guardian Name*** _____

Parent / Guardian Phone _____ **Parent / Guardian Email** _____

Dear Physician,

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

Physician Signature* _____

Date Signed* _____

Printed Physician Name* _____

TX Medical License Number* _____

Practice Address* _____

Practice Phone Number* _____



For questions, contact the student's campus or the district nurse @ Holly.beims@whitneyisd.net.