School Health Services Medical Provider Certification

Medical Provider Name: _____ Medical Specialty: _____

Student Name: _____ Date of Examination: _____

Medical Provider Attestation:
I am familiar with the student and the situation which resulted in school exclusion. I am currently treating the student for this condition and certify that he or she no longer presents with an imminent medical concern or is no longer contagious. The student is cleared to safely return to school on _____.
(date)

Provider's Phone: _____ Diagnosis or Treatment Comments: _____

_____

Recommendations or Restrictions:

_____

Providers Signature: _____ Date: _____

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Physician Certification of Serious or Life-Threatening Illness

Texas Education Code Sec 25.087 states: "(b) a school district shall excuse a student from attending school for: (3) an absence resulting from a serious of life-threatening illness or related treatment that makes the student's attendance infeasible, if the student or the student's parent or guardian provides a certification from a physician licensed to practice medicine in this state specifying the student's illness and the anticipated period of the student's absence relating to the illness or related treatment.

Student Name: _____ Date of Birth: _____ Student ID:_____

Campus: _____ Grade: _____ Phone Number: _____

Parent Name: _____ Parent Email: _____

For Physician Use Only: By signing below, I certify that the named student is experiencing a serious or life-threatening illness as specified, or a related treatment to that specified illness, that makes attendance at school for any part of the day infeasible for the anticipated period specified. I further certify that I am licensed to practice medicine as a physician in the state of Texas.

Physician's Name: _____ TX Medical Board License Number: _____

Physician's Phone: _____ Diagnosis or Treatment Comments: _____

Start Date for Period of Infeasibility: ___/____/___ Anticipated Return Date: ___/____/___

Providers Signature: _____ Date: _____