Peoria Unified School District #11
Medical Certification of a Chronic Health Condition

(To be completed by a physician, chiropractor, physician assistant or registered nurse practitioner and this form expires at the end of the current academic year)

Acknowledgment of Disclosure of HIPAA protected information:
The student, through their parent/guardian, is hereby requesting the below information for the benefit of the student's education. Disclosure is permitted by 45 C.F.R. §164.503(a).

Type or print Parent/Guardian Name **Phone** **Date**

Parent/Guardian Signature

20 - 20

Name of Student **Birthdate** **Grade** **School Year**

Address of Parent(s)/Guardian

Please check anticipated absences related to this chronic health condition only. Besides absences for illness, this also includes absences related to doctor or treatment appointments, upcoming surgeries or hospitalizations for the current academic year.

☐ 5-15 days ☐ 16-30 days ☐ >30 days

PHYSICIAN COMPLETES THIS SECTION

Physician's Statement (Include medical diagnosis, prognosis, anticipated surgeries, treatments or hospitalizations and/or physical limitations affecting physical education activities that may interfere with school attendance.)

I hereby certify this student as having a chronic health condition that may result in frequent absences during the school year, exceeding 5 per semester.

Physician Name **Signature** **Date**

Physician Address **Office Telephone Number**