Cholla Academy
Medical Certification of a Chronic Health Condition

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

20 -20

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

Name of Parent(s)/Guardian **Phone** **Grade**

Address of parents(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 **Physician Signature** **Date**

Physician Address **Office Telephone Number**