North East School District
Chronic Condition Form

Official Use
Start Date _____
End Date _____
Staff Notice _____
By Whom _____

Student Name (printed) _____ Date of Birth_____ Grade_____

From: Elementary Nurse: Kiersten Lawrence RN, CSN ext. 3012
Fax- (814) 725-0821
Middle School Nurse: Mindi Fisher RN, CSN ext. 2014
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High School Nurse: Christie Austin LPN ext. 1014
Fax (814) 725-3357

North East School District will authorize absences resulting from a **chronic medical condition or an extended illness** once this form is on file with the Health Office. Your student's healthcare provider **must** complete the medical information section below before the form is returned to the Health Office. The start date may be backdated only by one month from the date the form is received in the office.

When reporting an absence, indicate the absence is due to the chronic condition listed below. In accordance with attendance regulations, absences for any other reason must be identified as such. Please be advised that while this form may excuse an absence, the student is not exempt from completing school assignments and responsibilities.

Your signature also authorizes a release of information between the school nurse and healthcare provider regarding the student's chronic health issue and its impact on school attendance. The school nurse may request updated information at any point during the school year.

Parent/Guardian signature _____ Date _____
Daytime phone number _____ Alternate Number _____

Health Care Provider:
This from provides documentation regarding this student's chronic or extended health condition that may cause absences from school.

MEDICAL INFORMATION
Information will be part of the student's confidential health record

Diagnosis that may affect student attendance _____

Start date this diagnosis affected school attendance _____ End date _____

Please provide a specific description of why/how you expect this diagnosis may impact school attendance
_____
_____

Estimated frequency of absences from school, including appointments:
Number of days/week _____ or Number of days/month _____
Comments/Explanations _____
_____
_____

List School-related restrictions: _____

_____ _____
Signature of Healthcare Provider Printed name of Healthcare Provider

Date _____ Office Phone_____ Office Fax _____