Chronic Medical Condition Absence Form

RN verified _____

Student_____ Grade_____ Date_____

Date of Birth_____ School_____ Teacher_____

The Appleton Area School District will authorize absences resulting from a chronic medical condition or extended illness once this form is on file with the Health Office, along with the attached Medical Information form that must be completed by your child's health care provider and returned to the school Health Office. The District will only backdate absences for a chronic medical condition two weeks from the date this form and the Medical Information form is received by the Health Office.

When reporting an absence to school, you must indicate that the absence is due to the chronic condition listed on the Medical Information form. In accordance with attendance regulations, absences for any other reason must be appropriately identified.

Please be advised that while the Medical Information form may excuse an absence, your child is NOT exempt from completing school assignments and responsibilities. Furthermore, an excuse from a health care provider must be in writing and state the time period for which it is valid, not to exceed 30 days per Wis. Stats. § 118.15(3)(a).

Wisconsin Statute § 118.15(1)(a) requires public school students to attend school full-time. Students may be excused from school or class participation if medical documentation is received from the student's health care provider and the reason complies with Board of Education policy. The District considers accommodations and provides alternative activities if students are medically unable to attend school or participate in specific classes.

Your signature authorizes the release of information and communication between the Appleton Area School District school nurse or attendance officer, and your child's health care provider regarding the diagnosis that may affect your child's attendance. The District may ask the health care provider about your child's diagnosis and how the diagnosis is expected to impact your child's attendance. This release of information expires one year from the date this form is signed.

The school nurse or attendance officer may request updated information or prescriptions at any point during the school year from your child's health care provider.

To Be Completed By Parent/Guardian:

Parent/Guardian Name_____

Parent/Guardian Signature _____ Date_____

Phone Number _____

Chronic Medical Condition Absence Form: Medical Information

This information will be part of the child's health and attendance records.

TO BE COMPLETED BY HEALTH CARE PROVIDER:
This form provides documentation regarding the child's chronic or extended health condition that may cause absences from school. Please specify symptoms that would not warrant an office visit but would require the student to stay home from school. The school nurse or attendance officer may contact you for additional information or prescriptions.

Student_____ Grade_____ Date_____

Diagnosis that may affect student's attendance: _____

_____

Start date the symptoms of the diagnosis prevented school attendance:_____

Date when symptoms are expected to subside:_____

Date student is expected to return to school:_____

Per AASD Policy 430 and Wis. Stats. § 118.15 (3)(a): If a child is expected to be absent over 30 days, another written statement is required.

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

_____

_____

Estimated frequency of absences from school, including appointments:

Number of days per week:_____ **OR** Number of days per month:_____

Additional comments, restrictions, or instructions, including any preventative measures that may help increase the student's attendance at school:

_____

_____

Printed Name of Healthcare Provider: _____

Signature of Healthcare Provider: _____ Date: _____