Mobile County
PUBLIC SCHOOLS
Learning Today. Leading Tomorrow.

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Superintendent Chresal D. Threadgill

CHRONIC AILMENT PHYSICIAN'S STATEMENT OF ILLNESS

STUDENT NAME:_____DATE:_____

DATE OF BIRTH:_____

This student is a patient of mine and has been diagnosed with the condition outlined below. This condition may necessitate absences from school.
THIS STATEMENT MUST BE SUBMITTED TO YOUR CHILD'S SCHOOL AT THE BEGINNING OF THE FIRST SEMESTER ALSO UPDATED AND RESUBMITTED AT THE BEGINNING OF SECOND SEMESTER.

Diagnosis:

Anticipated number of absences:

Requirement for returning to the physician's office:

Physical limitations the student may have in getting to school:

Other pertinent information related to this illness:

Doctor's name:_____

Address:_____

Phone:_____FAX:_____

_____ _____
Physician's Signature (REQUIRED) Date