SACS
SOUTHWEST ALLEN COUNTY SCHOOLS

Copies Sent: ❑ Rachael Harshman
❑ School Nurse
❑ Office

CHRONIC ILLNESS FORM

(NOTE: I.C. 20-33-2-18 requires this form to be signed by a licensed physician)

Student Name _____

School _____Grade _____

Date condition began _____ Anticipated date of return to school _____

Diagnosis/Description of Condition: _____

_____

_____

Duration of Condition:

_____ permanent (remainder of the school year)

_____ temporary (ending on the date of _____)

Anticipated School Attendance:

_____ Regular daily attendance at school

_____ Irregular school attendance—not to exceed _____ days absent per month

If student will have irregular attendance, please explain. Please be as specific as possible:

_____

_____

_____
Physician's Signature

_____
Date

_____
Print Physician's Name

_____
Physician's Telephone Number

_____
Physician's Address

Return Completed Form to:
School:
Attention:
Address:
Fort Wayne, IN 46814

17-18

OFFICE USE ONLY

_____ _____
Counselor Signature Date

_____
Date Received

Preparing today's learners for tomorrow's opportunities.

Rachael Harshman ♦ Director of Student Services
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