

- Copies:  Director of Student Learning  
 School Nurse  
 Office



**SACS**

SOUTHWEST ALLEN COUNTY SCHOOLS

Date Received: \_\_\_/\_\_\_/\_\_\_

**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

**OFFICE USE ONLY**

\_\_\_\_\_  
 Counselor Signature

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Date Received

***Preparing today's learners for tomorrow's opportunities.***

Jeanine Kleber ♦ Director of Student Learning

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