

**ROCHESTER COMMUNITY SCHOOLS
CHRONIC ILLNESS STATEMENT**

Student Name: _____ Grade: _____

Address: _____

Home Phone: _____ Business Phone: _____

TO BE COMPLETED BY THE DOCTOR

The above named student is currently under my medical care and has been since (date) _____
_____. My diagnosis indicates that the student illness is _____
_____.

Would the effect of this illness cause the student to be absent more than 12 times in a 20 week
grading period? YES NO

May the school contact your office for additional information if necessary? YES NO

Any additional comments: _____

DOCTOR'S NAME/SIGNATURE: _____
Address: _____
Phone: _____

THANK YOU FOR YOUR TIME AND COOPERATION

For office use only:

- Approved
- Needs Yearly Update
- Not approved pending further review
- Does Not Need Yearly Update

PRINCIPAL'S SIGNATURE: _____ Date: _____