North East School District
Chronic Condition Form

Student Name (printed) __________________________________________ Date of Birth ___________ Grade ______

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North East School District will authorize absences resulting from a chronic medical condition or an extended illness once this form is on file with the Health Office. Your student’s healthcare provider must complete the medical information section below before the form is returned to the Health Office. The start date may be backdated only by one month from the date the form is received in the office.

When reporting an absence, indicate the absence is due to the chronic condition listed below. In accordance with attendance regulations, absences for any other reason must be identified as such. Please be advised that while this form may excuse an absence, the student is not exempt from completing school assignments and responsibilities.

Your signature also authorizes a release of information between the school nurse and healthcare provider regarding the student’s chronic health issue and its impact on school attendance. The school nurse may request updated information at any point during the school year.

Parent/Guardian signature __________________________________________ Date ___________
Daytime phone number ___________________________ Alternate Number __________________________

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Health Care Provider:
This form provides documentation regarding this student’s chronic or extended health condition that may cause absences from school.

<table>
<thead>
<tr>
<th>MEDICAL INFORMATION</th>
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<tr>
<td>Information will be part of the student’s confidential health record</td>
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Diagnosis that may affect student attendance __________________________________________________________

Start date this diagnosis affected school attendance _______________ End date _______________

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

Estimated frequency of absences from school, including appointments:
Number of days/week ___________________________ or Number of days/month ___________________________

Comments/Explanations __________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________

List School-related restrictions: ________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________

Signature of Healthcare Provider __________________________________________ Printed name of Healthcare Provider

Date ___________________ Office Phone ___________________ Office Fax ___________________