

THIS FORM MUST BE UPDATED EACH SCHOOL YEAR.

**Logan County Schools
Chronic Health Condition Statement (M5-M6 Code)**

Student Name: _____	School Year: <u>2021-22</u>
Address: _____	Phone #1: _____
School: _____ Grade: _____ DOB: _____	Phone#2: _____

This form is to document any chronic medical condition or physical disability that may require multiple or regular absences from school. The condition making the absences necessary *must be documented annually* by a physician and presented to the school's SAT, IEP, or 504 team for review. Students with proper documentation of a chronic medical condition or physical disability require only a parental excuse for absences related to those conditions or disabilities. Parents must notify the school when the child is absent and follow up with a note upon return, indicating the desire to use the M5/M6 code. This document does not excuse the student from completing all required class assignments. Missed assignments are the responsibility of the parent/guardian/student and must be completed in a timely manner.

To the Parent/Guardian:

I grant permission to my child's physician to release any and all information to Logan County Schools regarding my child's medical condition.

Parent/Guardian's Signature: _____ Date: _____

To the Physician:

Logan County Schools is requesting that you verify that this child has a chronic condition that may impact regular attendance at school. Please document the chronic medical condition or physical disability warranting special consideration for a pattern of chronic or multiple absences. Please note that this document could be used in court if the student becomes truant. Also, students/parents are responsible for all missed assignments.

Please state below the child's chronic medical condition or disability and how it may impact attendance at school. Please have the parent return the completed form to their child's school.

Physician's Statement:

Medical Diagnosis: _____

Date of Onset: _____ Date of Last Office Visit for Condition: _____

Medications: _____

Impact on Attendance: _____

*****Chronic Medical Code cannot be used on a daily basis.**

How many days of absences should be expected on a monthly basis? _____

Physician's Name: _____

Physician's Signature: _____ Date: _____

Address: _____ Phone: _____

By signing this form, you verify that the student is unable to attend school on a regular basis and should be excused for the days or partial days missed.

Revised:2/4/2021 * MUST BE SIGNED BY LICENSED PHYSICIAN ONLY.*****