ATTACHMENT A

Medical Provider Statement
for Determining Student Long Term Medical Absence

This section is to be filled out by a properly licensed medical provider responsible for diagnosing and treating the student. In order for a district to exempt a student from compulsory attendance, the student must provide satisfactory evidence in the form of a signed statement from a qualified healthcare professional that the diagnosed condition of the student prevents or renders inadvisable attendance at school and requires a Long Term Medical Absence.

*For these purposes, a long-term medical absence means a student is or will be absent from the student's school of record for ten (10) or more consecutive days due to a medical injury or illness as verified by a medical provider.

Date:_____

Patient/Student Name: _____Date of Birth:_____

Medical Diagnosis:_____

Prognosis: Good _____ Fair _____ Poor _____

Is the student medically able to attend full or partial days at the regular campus school?

___ **Yes**, the student is able to attend (full days) (partial days) in the regular school setting **without** any type of modifications or special provisions.

___ **Yes**, the student is able to attend (full days) (partial days) in the regular school setting **with** the following modifications or special provisions.

___ **No**, the student is medically unable to access a regular school setting.

If yes, for full or partial days, what issues, modifications, or provisions do staff need to be aware of to help the student be successful:

_____
_____

Note: This information will be provided to the school so that appropriate accommodations can be made, as necessary. You may skip the remaining questions.

Please sign the form at the bottom and fax/deliver to the school's health office.

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If No, the student ***is not*** medically able to attend school, please provide specific reason (s) why the student is unable to attend school at this time.

_____

_____

How does the student's condition specifically limit his/her ability to access classes in the regular school setting?

_____

_____

1. What is the approximate length of time you anticipate the student will need alternative education services?

   _____

2. When is the follow-up evaluation appointment scheduled?_____

<u>Treatment Plan & Education (required for Long Term Medical Absence)</u>

1. What is the current treatment plan and/or medical interventions?

   _____

   _____

2. What is the expected duration of the treatment plan?

   _____

   _____

3. Is this chronic physical condition unlikely to substantially improve within one year?

   _____

4. Anticipated date of student's return to school?

   _____

   What recommendations or possible accommodations do you suggest to assist this student in accessing their education?

_____

_____

_____

_____

Remarks/Comments:

_____

_____

_____, Medical Provider's Signature

_____, Medical Provider's Printed Name

Contact information:

_____
Address

_____
Phone Number

_____
Fax Number

_____
Email

Thank you for your assistance! Please fax/deliver this information to the school health office.

Attention:_____ at _____.
(Nurse or Health Assistant)
(School)

School Use only

Date received by medical provider: _____

Sent to school 504 Chair, _____ on _____.
(Name) (date)