Cabell County Schools Chronic Medical Condition Form

Student Support Services Office Michael J Krenzel II, Coordinator Phone: 304.528.5415
Fax: 304.528.5125

Parent/Guardian: This form must be signed and submitted at the beginning of every semester (August and January). *Additionally, for the child's absence to be excused as "Chronic Medical", you must provide a written note to the school stating that the child's absence was related to the chronic medical condition.* ***If the child's absences exceed the approved amount, an additional doctor's excuse will be required for the absence to be excused.***
Note: This document does not excuse the student from completing all required class assignments.

I understand the terms above and give consent for my child's physician to release information to Cabell County Schools regarding my child's chronic medical condition as well as permission to communicate with my child's physician regarding the documented chronic medical condition.

Parent/Guardian's Signature: _____ Date: _____

Physician: The parent/guardian of the child listed below notified Cabell County Schools that this student has a chronic health condition impacting his/her regular school attendance. School attendance is crucial for all students. Learning that takes place in the classroom is an essential component of the educational process. Class time provides instruction and interaction, when lost, is irretrievable. Cabell County Schools request that you verify there is a chronic condition that impacts his/her regular attendance. It is our goal to provide each student with a quality education for future success.

Please note: This form will become a court document if this student becomes truant.

Student: _____DOB: _____
School / Grade: _____ /_____ WVEIS # _____ Phone: _____
Parent: _____

Please complete the information regarding the above mentioned student's medical condition requiring intermittent absences throughout the school year. This information will allow staff to provide needed support for this student. ***Please note: Should the student only require medication or specific care during the school day, trained, designated staff is available at each school.***

Medical Diagnosis: _____
Date of Onset: _____
Medications: _____
_____
Date of Last Office Visit for this Condition: _____
Symptom(s) exhibited, impacting school attendance and requiring absence(s): _____
_____
How often should this excuse be used to cover absences each month? _____ (*Not to exceed 8 days/month.)*

Through your signature; you certify that this student is unable to attend school on a regular basis and should be excused for the days or partial days missed, as noted. As the attesting physician, you also understand, you can be subject to testify in court to the medical condition and treatment of this student, if deemed necessary.

_____ _____
Physician's Name (Please Print) Date

_____ _____ _____
Physician's Signature Physician's Phone Number Fax Number

Office Use Only: Entered in WVEIS_____ Teacher Notified _____ School Nurse Notified_____