



**EXCLUSION AND EXEMPTIONS FROM SCHOOL ATTENDANCE MEDICAL CERTIFICATION OF STUDENTS
WITH CHRONIC HEALTH CONDITIONS**

(TO BE COMPLETED BY CERTIFIED HEALTH PROFESSIONAL ONLY)

Student Name: _____ DOB _____ YOG _____ School Year _____

Date of initial consultation: _____

Medical diagnosis: _____

Symptoms: (Please check all that apply)

Neurological System

☐ Lethargy
☐ Seizures
☐ Blurred Vision

Respiratory System

☐ Weakness / Fatigue
☐ Continual Coughing
☐ Difficulty Breathing

Gastrointestinal System

☐ Nausea / Vomiting
☐ Constipation
☐ Abdominal Pain

Cardiovascular System

☐ Weakness / Dizziness
☐ Palpitations
☐ Rapid Pulse
☐ Arrhythmia
☐ Pain

Ear, Nose & Throat

☐ Chronic Infections
☐ Severe Allergies
☐ Severe Asthma
☐ Fever
☐ Pneumonia / Bronchitis

Additional Symptoms: _____

Medical Prognosis: _____

Physical limitations affecting physical education activities: _____

Please indicate the anticipated absences due solely to chronic health illness that may interfere with school attendance during this school year. Please note that if no selection is made, the form will not be accepted.

☐ Less than 10 days

☐ 10 to 20 days

☐ Hospitalization

☐ Therapy

☐ Other: _____

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Other relevant information: _____

Your patient is a student at The Catholic High School of Baltimore. We understand that she has been diagnosed with a chronic medical condition. Please list any symptoms that would not warrant an office visit but would require the student to stay home from school. **Please be advised that this documentation will expire one year from the date signed by the physician.** _____

Physician Name (Print)

Physician Signature

Address

Today's Date

Telephone / Fax

THIS SECTION TO BE COMPLETED BY PARENT/GUARDIAN

I hereby request and authorize the exchange of information on the above diagnosis pertaining to my child between:

_____ and _____
Physician Name School Name / School Nurse

I understand that:

- 1. I am still required to report absences to the main office as policy requires.**
- 2. Only absences related to the illness listed and the number indicated by the doctor are excused.**
- 3. Per policy, if my daughter is absent for three (3) or more consecutive days due to the illness listed, I need to seek medical attention and submit a doctor's note when my child returns to school.**

Parent Signature

Date