Medical Certification of Student with Chronic Health Condition

Student's Name _____ Matric # _____ DOB _____ Grade _____

Parent/Guardian's Name _____ Phone Numbers _____

Parent E-Mail address _____

Address _____ City _____ Zip _____

School _____ Date of Consultation _____

The following information needs to be completed by a licensed medical doctor, podiatrist, chiropractor, osteopathic physician, naturopathic physician, physician's assistant, or nurse practitioner.

Diagnosis _____

Please check – Diagnosis due to: ☐ Injury ☐ Chronic Illness

Please initial if the student's condition is permanent _____

Identify limitations affecting school activities: _____

Physical activity limitations: _____

This student may be unable to attend regular classes for intermittent periods of one or more consecutive days because of the illness, disease, accident, or pregnancy. I expect the student's duration of irregular attendance will be _____, if not permanent.
Length of time

Print Healthcare Provider's Name _____ Licensed Title _____

Healthcare Provider's Signature _____ Date _____

Cc: Student Health Folder, Student Cum File
JHD-E1 – Medical Certification of Student with Chronic Health Condition

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