



321 South 5th Street, Rockport, IN 47635
Tel: 812-649-2591, Fax: 812-649-4249

Physician's Certificate of Student Illness or Incapacity to Attend School

To Be Completed By the Parent/Guardian

Student Name: _____ Date of Birth: _____

School: _____ Grade: _____

Parent Name: _____ Phone Number: _____

To Be Completed By the Physician

Diagnosis/Description of illness/condition that has precluded or currently precludes the student's attendance at school:

Date student first seen by physician for this illness/condition: _____

Date student is to return to be seen by physician: _____

Anticipated date student may return to school: _____

Based on physician's diagnosis and professional judgement, the school should expect the student's attendance to be (please check one):

- Regular Daily Attendance** Student can attend school on a regular basis
 Irregular Daily Attendance Student cannot attend school on a regular basis and will have multiple absences without requiring doctor visits
 Homebound Instruction Student cannot attend school at all

Physician Signature: _____ Date: _____

Physician Printed Name: _____ Phone Number: _____

Physician Address City, State, Zip: _____

This certificate may be completed by an Indiana physician, an individual holding a license to practice osteopathy or chiropractic in Indiana, or a Christian Science practitioner who resides in Indiana and is listed in the Christian Science Journal. (IC 20-33-2-18)