



# BUTLER ACADEMY

## CHRONIC OR EXTENDED ILLNESS VERIFICATION FORM

Student Name \_\_\_\_\_ DOB \_\_\_\_\_ School Year: \_\_\_\_\_

**Dear Physician:**

Your patient, a student enrolled at Butler Academy, has reported to us that he/she has a chronic illness. We define a chronic illness as sickness of long duration or frequent recurrence that necessitates absence from school.

The South Carolina Compulsory Attendance Law requires a child to attend school a minimum of one hundred eighty (180) days a year with only ten (10) absences. If the student's physician confirms a chronic illness, the absence(s) will not count against the student for credit purposes. Please complete the boxed off section below to either verify or disprove the chronic or extended illness and **return to the school by fax to 844-917-2780**. Thank you!

**THIS SECTION IS TO BE COMPLETED BY PHYSICIAN**

I verify that \_\_\_\_\_ has a chronic/extended illness which will necessitate  
*STUDENT'S NAME*

his/her regular periodic absences from school.

**Illness/Diagnosis:** \_\_\_\_\_ **Start Date:** \_\_\_\_\_ **End Date:** \_\_\_\_\_

Symptoms of this illness includes:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If the student reports that any of these symptoms are debilitating enough to keep him from school, please excuse that absence.

\_\_\_\_\_  
*PHYSICIAN'S NAME*                                                  *PHYSICIAN'S SIGNATURE*                                                  *DATE*

I cannot approve \_\_\_\_\_ as having a condition which would classify him/her  
*STUDENT'S NAME*

as chronically ill.

\_\_\_\_\_  
*PHYSICIAN'S NAME*                                                  *PHYSICIAN'S SIGNATURE*                                                  *DATE*

**PLEASE NOTE:**

- Chronic illness forms only cover absences due to the illness/condition as specified by the student's physician above.
- The chronic illness form must be renewed each school year, if the illness/condition is ongoing.
- It is the responsibility of the parent/guardian to request the form from the school, take the form to the student's physician for completion, and ensure the completed form is **returned to the school by fax to 844-917-2780**.
- This form only covers absences related to the specified illness/condition and does not excuse the student from any assignment missed during his/her absence(s).
- All missed work/assignments should be made up within three (3) days of the student's return to school.
- The school ensures confidentiality of student healthcare information and appropriate information sharing.

\_\_\_\_\_  
*SCHOOL NURSE SIGNATURE*                                                  *DATE*                                                  *SCHOOL OFFICIAL SIGNATURE*                                                  *DATE*