



**School/Parent Instructional Agreement for
Students with Chronic Health Conditions during the School Year _____**
(see time frame below)

**This form to be completed after the medical certification form has been completed by health professional.
This form must be updated each school year.**

Student's Name: _____ Date: _____
(Received at School)

School: _____ Grade: _____ DOB: _____ Date: _____
(Medical Certification)

Parent's/Guardian's Name: _____ Work Phone: _____

Address: _____ Home Phone: _____ Cell Phone: _____

Timeframe: 2-4 weeks 1-3 months 3-6 months
 Duration of school year (from date of health professional signature found on Medical Certification)

Complete the following checklist:

- 1a. Medical certification of chronic health condition (diagnosis, prognosis, and inability to attend school regularly) fully Completed.
- 1b. Medical certification of physical limitations for physical education.
- 2. School has noted chronic condition on attendance register/student database as CHC.
- 3. School nurse informed of student's chronic health condition and noted in Student Information System (SIS) and nurse's database.
- 4. Student's teacher(s) informed of student's chronic health condition.
- 5. If applicable, school counselor informed of student's chronic health condition.
- 6. Physical education activities/requirements adapted according to medical certification.

Instructional Agreement - This agreement shall be made within 15 days from the school's receipt of the Medical Certification.

Teachers agree to provide homework and contact during absences for the designated timeframe. Please describe.

Parent/Guardian agrees to return completed homework to the school for absences during the designated timeframe as follows (at minimum, weekly): _____

Relevant information: _____

Signatures:

Teacher: _____ Parent: _____

Principal: _____ Date: _____



Medical Certification: Chronic Health Problem

This form is to be completed by a health professional and returned to the school nurse within 30 days, prior to completing the Instructional Agreement
This form must be updated each school year.

Student's Name: _____ School: _____ Date: _____

School Nurse: _____ Grade: _____ DOB: _____

Parent's/Guardian's Name: _____ Work Phone: _____

Address: _____ Home Phone: _____ Cell Phone: _____

Definition: A.R.S. §15-346, Pupils with Chronic Health Problems (CHP) 1. Pupils who are not homebound, but who are unable to attend regular classes for intermittent periods of one or more consecutive days because of illness, disease, or accident as certified by a health professional who is licensed pursuant to Title 32, Chapter 7, 8, 13, 14, 15, 17, or 25. These licensed health professionals include: psychiatry, psychology, podiatry, chiropractic medicine, naturopathic medicine, osteopathy, physicians assistants, or registered nurse practitioners. The student must be examined by a licensed healthcare professional and certified as being a student who may frequently be absent from school due to a chronic health problem requiring management on a long-term basis but is NOT expected to be absent enough days to require homebound services (unable to attend class for 60 days/or three school months). If absences amount to 3 school months (or sixty (60) school days) another chronic health certification must be obtained and reviewed by teacher and parent.

1. Diagnosis: _____
2. Estimated Duration: _____
3. Limitations Affecting Educational Activities and Attendance: _____

4. Physical Education Adaptations: _____

5. Anticipated surgeries, treatments, or hospitalizations that may interfere with regular school attendance. _____

I hereby certify the above student should/ should not be registered as having a chronic health condition during the school year _____ for the time indicated below.

Timeframe: 2-4 weeks 1-3 months 3-6 months
 Duration of school year (from date of health professional signature found on Medical Certification)

Name of Health Professional (please print): _____

MD ND DC NP PA DO DPM Agency: _____

Address: _____ Phone: _____

Signature: _____ Date: _____