

SEDGWICK COUNTY AREA EDUCATIONAL SERVICES INTERLOCAL COOPERATIVE

620 Industrial, Box 760  
Goddard, KS 67052  
(Phone) 794-8641 - (Fax) 794-2439

**PHYSICIAN'S STATEMENT**

\_\_\_\_\_ **Student's Name** \_\_\_\_\_ **Date** \_\_\_\_\_

\_\_\_\_\_ **Date of Birth** \_\_\_\_\_

Please specifically describe the above named student's medical condition.

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

The above described medical condition renders this student physically incapable of attending school or any school functions.

Yes.....Probable Duration \_\_\_\_\_  
(days, weeks, months)

No

I, \_\_\_\_\_, being the physician of the above named student, hereby certify that the medical condition described above renders this student to be physically incapable of attending school or any school functions.

\_\_\_\_\_  
PHYSICIAN'S SIGNATURE