Indiana Department of Education

Center for School Improvement and Performance
Office of Student Services
State Attendance Officer
Room 229, State House
Indianapolis, IN 46204-2798

Certificate of Incapacity

(Note: I.C. 20-8. 1-3-20 requires this form to be signed by a licensed physician)

Student's Name _____

Grade _____ Date of Birth _____ Social Security Number _____

School _____ Principal _____ Telephone Number _____

Part 1 (To Be Completed by the Physician)

Diagnosis of the Condition _____

_____

_____

Duration of the Condition (check one) _____ Permanent _____ Temporary

Anticipated Date the Student May Return to School _____, 20_____

Date Student Should Return for Re-examination _____, 20_____

Part 2 (To Be Completed by the Physician)

Based on your diagnosis and professional judgment, the school should anticipate the student's school attendance to be (check one)

_____ Regular Daily Attendance

_____ Irregular Daily Attendance (please explain)

_____

_____

_____ Seasonal (please explain)

_____

_____

If an individualized program is warranted due to anticipated irregular school attendance or restriction of physical activities, the school may submit a written individualized program for the physician's approval and signature

Please Return Form To:
School City of Hammond
Health Services Office
41 Williams Street
Hammond, IN 46320
Phone 219-933-2400
Fax 219-989-3957

Physician Signature _____

Physician Printed Name_____

Physician Address _____

Telephone Number _____