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.

Return form to:

_____
_____
_____
_____

_____
Physician's Signature

_____
Physician's Printed Name

_____
Physician's Address

_____
Telephone Number