



ROYCEMORE

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100 YEARS Proud history
Inspired future

CHRONIC CONDITION FORM

Student/ Faculty member's Name: _____

Date: _____

This student has a chronic condition caused by:

- ____ asthma
- ____ allergies
- ____ reflux
- ____ other (please specify)

This student has *other symptoms* that are part of COVID-19 screening that are caused by a chronic condition:

Symptom(s):

Condition(s):

Physician's Signature: _____

Date: _____

Parents are responsible for reporting symptoms that are atypical of the above-noted condition(s) or are presenting in a more severe fashion. Any individual with atypical or more severe symptoms screens positive for COVID-like illness and should not come to school until receiving a negative PCR COVID test or evaluated by a physician, per Roycemore protocol.

Parent/ Faculty member's Signature: _____