CHRONIC ILLNESS VERIFICATION FORM

This form is to be completed by an authorized licensed medical physician, surgeon, dentist, optometrist, podiatrist, nurse practitioner, nurse midwife or physician assistant. Copy of business card or letterhead is required and all sections marked with an * must be completed in order for the form to be valid.

_____

Student Last Name First Name Middle Initial DOB: month/day/year Grade/School Year

PLEASE FORWARD COMPLETED FORM VIA FAX TO:

_____

School Name Contact Person School Fax # School phone #

Dear Physician: For our records, please list the chronic illness diagnosed for the student. Also, please list or check symptoms that would not warrant an office visit but might require the student to stay home from school. This will allow the parent to verify the illness without having to bring them to your office for an examination or note to be excused from school. This verification form will expire at the end of the academic school year it was received.

***CHRONIC ILLNESS/MEDICAL DIAGNOSIS**: _____

*SYMPTOMS: _____

Neurological System
- □ Lethargy
- □ Dizziness/Unsteadiness
- □ Numbness in Extremities
- □ Petit Mal Seizures
- □ Grand Mal Seizures
- □ Severe Headache
- □ Blurred Vision

Integumentary System
- □ Sun Lesions
- □ Infections
- □ Edema

Musculoskeletal System
- □ Pain
- □ Inflammation/Swelling

Respiratory System
- □ Weakness/Fatigue
- □ Pallor/Cyanosis
- □ Continual Coughing
- □ Congested Airway
- □ Difficulty Breathing
- □ Pain

Cardiovascular System
- □ Weakness/Dizziness
- □ Pallor/Cyanosis
- □ Palpitations
- □ Rapid Pulse
- □ Arrhythmia
- □ Pain
- □ Fevers/Infection

Gastrointestinal System
- □ Nausea/Vomiting
- □ Diarrhea
- □ Constipation
- □ Abdominal Pain

Genitourinary System
- □ Bladder/Kidney Infection
- □ Fever

Ear, Nose & Throat
- □ Chronic Infections
- □ Severe Allergies
- □ Severe Asthma
- □ Fever
- □ Pneumonia/Bronchitis

Additional Comments: _____

*Expected **Frequency** of episodes: _____*Approx. **Length** of absence/episode: _____day(s)

(Example: monthly- 4 times/semester)

_____

*Authorized Medical Provider Name (Print) *Signature *Date

PARENTAL AUTHORIZATION: I hereby request and authorize the exchange of information on the above diagnosis and symptoms pertaining to my child between designated school staff and licensed medical provider listed above. I further understand that with this verification, I must submit a written explanation to the school to verify each absence and that should the frequency or length of absences exceed the number authorized above, contact to the medical provider may be made by designated school staff. Absences will be reviewed on a semester by semester basis as per attendance policy.

*Parent/Guardian Signature:_____ Date: _____

Approved ____ Denied ____ Nurse Signature: _____ Date: _____

Administrator Signature: _____ Date: _____

Counselor Signature: _____ Date: _____