Victor Valley Union High School District

16350 Mojave Dr. Victorville, CA 92395
760.955.3201 ex. 10238

CHRONIC ILLNESS VERIFICATION FORM (CIVF) INFORMATION

The Chronic Illness Form allows parents to excuse absences due to a specific medical condition with the same authority as a medical professional. Below are guidelines for completing the form correctly to establish and maintain this authorization.

1) **Victor Valley Union High School District** does not accept any CIVF that does not have the expected frequency of episodes, length of absence, diagnosis, appropriate symptoms listed, Physician's or Medical Group letterhead/business card attached and appropriate signature(s). Please return the form to parent for completion.

2) The school site may fax the CIVF back to the Physician's office to verify the document's authenticity. An administrator or their designee must refuse acceptance of any CIVF found to be fraudulent.

3) Please monitor the expected frequency and length of episode for absences excused for reasonable compliance with the Physician's guidelines outlined on the form. If there is a concern about the child not making academic progress due to these absences or that the privilege is being misused, the school will contact the student and/or parent to discuss these concerns. For some chronically ill children, alternative educational programs may meet their needs more appropriately.

4) If the site has unresolved concerns, after talking with the student and/or parent, designated Health Services staff will contact the authorizing Physician with specific questions related to the diagnosis and absenteeism. We will refer to the CIVF if the parent initials require contact with them prior to accessing the Physician.

5) Remember, the form expires at the end of the academic year. Obtain a new form annually.

STUDENT AND PHYSICIAN VERIFICATION

Student:_____ DOB: _____ Grade:_____

Forward to:_____ _____
School FAX number

Dear Physician,

Your patient is a student enrolled in [enter school district here]. For your records, please list the chronic illness diagnosed for the student. Also, please check or list symptoms that would not warrant an office visit, but might require the child to stay home from school. This will allow the parent to verify illnesses, by listing in writing to the school the symptoms designated below, without bringing the child to your office for an examination. This document expires at the end of the academic year that it is/was received.

_____ _____
Physician signature and printed name here Date

Please Attach Business Card

Address_____

Chronic Illness/Medical Diagnosis_____

Symptoms_____

Expected frequency of episodes_____
(for example: monthly, 4 times per school year, etc.)

Length of absences per episode_____

SYMPTOMS

Neurological System

__ lethargy

__dizziness/unsteadiness

__numbness in extremities

__petit mal seizures

__severe headache

__blurred vision

Respiratory system

__weakness/fatigue

__pallor/cyanosis

__continual coughing

__congested airway

__difficulty breathing

__pain

Gastrointestinal system

__nausea/vomiting

__diarrhea

__constipation

__abdominal pain

Integumentary system

__skin lesions

__infections

__edema

Musculoskeletal system

__pain

__inflammation/swelling

Cardiovascular system

__weakness/dizziness

__pallor/cyanosis

__palpitations

__rapid pulse

__arrhythmia

__pain

__fever/infections

Genitourinary system

__bladder/kidney infection

PARENT/GUARDIAN AUTHORIZATION

I hereby request and authorize the exchange of information on the above diagnosis pertaining to my child between Health designated staff of the **Victor Valley Union High School District** and the physician named above.

I request **Victor Valley Union High School District** to inform me, the parent/guardian signing this authorization before contacting the authorizing medical professional._____ (initial here to request).

This contact will only be made if the frequency or length of absences exceeds the numbers authorized above. **I further understand I must submit written explanations to verify each absence.**

Parent signature:_____ **Date:** _____