STUDENT AND PHYSICIAN VERIFICATION

Student Name: _____ DOB:_____ Grade:_____

Forward to:

_____ _____
School FAX number

Dear Physician,

Your patient is a student enrolled in Rockcastle County Schools. For our 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 Verification:

_____ _____
Physician signature and printed name here Date

Physician's address_____

Please attach business card here:

Chronic Illness/Medical Diagnosis_____

Symptoms_____

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

Length of absences per episode_____

On following page, the physician should check the specific symptoms of the child's illness.

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

The parent or guardian must sign the authorization for an exchange of information regarding the diagnosis.

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 Rockcastle County Schools and the physician named above.

I request Rockcastle County Schools 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: _____