Certification of Chronic Medical Condition

Optional Form for California Licensed MD/DO/NP/PA

STUDENT NAME (Last, First, Middle)	DATE OF BIRTH

Certification of chronic symptoms

I certify that this child has a physical or medical condition, specified below, with the following chronic symptoms that are unrelated to COVID-19, and recognize that a school health professional may call me for clarification or information about best management of this condition during the school day.

Recurrent or chronic symptoms:

Sign/Symptom(s)	Diagnosis and description of physical/medical condition(s) causing these symptoms Cite any abnormal labs, x-rays etc.	Year / Date Diagnosed
☐ Cough		
☐ Nasal congestion/rhinorrhea		
☐ Nausea/vomiting/diarrhea		
☐ Rash		
☐ Fatigue		
☐ Loss of taste/smell		
☐ Headache		
☐ Muscle/body aches		
☐ Poor feeding/appetite		
☐ OTHER: describe		

Current treatment for above medical condition(s): _____

_____

When this patient presents with symptoms of this chronic condition, would you like to assess and approve of school attendance first (to rule out COVID-19, for example) before the student resumes school attendance?

☐ Yes ☐ No Comments _____

Additional comments: _____

Licensed provider's **Printed** name, address, telephone & fax number:

Signature: _____

Please check: ☐ MD ☐ DO ☐ NP ☐ PA

License Number: _____

Date: _____