VALLEY VIEW LOCAL SCHOOLS
CHRONIC ILLNESS VERIFICATION FORM

DATE _____

STUDENT _____ DOB ___/___/_____ GRADE _____

FORWARDED TO _____ FAX # (_____) _____-_____
(school)

Dear Physician,
Your patient is a student enrolled in the Valley View Local School District. 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 it was received.

PHYSICIAN VERIFICATION

_____ _____
Physician Signature Printed Name

_____
Date

In order for the school to document the physician's address and phone number please attach a business card or copy of physician's letterhead to this form.

Chronic Illness/Medical Diagnosis: _____

Symptoms: _____

Expected length of absence per episode: ___ days. (For example: monthly, 4 times per school year, etc.)

Neurological system __ lethargy __ dizziness/unsteadiness __ numbness in extremities __ petit mal seizures __ grand mal seizures __ severe headache __ blurred vision Integumentary System __ skin 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/infections Genitourinary system __ bladder/kidney Infection __ fever	Gastrointestinal system __ nausea/vomiting __ diarrhea __ constipation __ abdominal pain Ear, Nose & Throat __ chronic infections __ severe allergies __ severe asthma __ fever __ pneumonia/bronchitis

Additional comments:

_____

_____

_____

_____

Please see next page for the authorization of exchange of information by parent or guardian.

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 Valley View Local School District and the physician named above, I request Valley View Local 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: _____