Victor Valley Union High School District
16350 Mojave Drive
Victorville, CA 92395
760-955-3201

CHRONIC ILLNESS VERIFICATION FORM

Student Name: _____Date of Birth: _____ Grade: _____
School Name _____ School Fax Number _____

Dear Physician,

Your patient is a student enrolled in Victor Valley Union School District. For our records, please list the chronic illness diagnosed for the student. Please check or list the 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 documentation expires at the end of the academic school year it was received.

To be Completed by Child's Physician

Physician's Name (please print) _____

Chronic Illness/Medical Diagnosis _____

Symptom(s): Expected Frequency _____ of episodes/length of absence/episode _____ day(s).
*i.e. monthly, 4 times/school year, etc

Neurological System
___ lethargy
___ dizziness/unsteadiness
___ numbness in extremities
___ petit mal seizures
___ grand mal seizures
___ severe headache
___ blurred vision

Respiratory System
___ weakness/fatigue
___ pallor/cyanosis
___ continual coughing
___ congested airway
___ difficulty breathing
___ pain

Cardiovascular System
___ weakness/dizziness
___ pallor/cyanosis
___ palpitations
___ rapid pulse
___ arrhythmia
___ fevers/infections
___ pain

Ear, Nose, & Throat
___ chronic infections
___ severe allergies
___ severe asthma
___ fever
___ pneumonia/bronchitis

Integumentary System
___ skin lesions
___ infections
___ edema

Genitourinary System
___ bladder/kidney infection
___ fever

Gastrointestinal System
___ nausea/vomiting
___ diarrhea
___ constipation
___ abdominal pain

Musculoskeletal System
___ pain
___ inflammation/swelling

Additional Comments:
_____
_____
_____

Physician Signature: _____ Date: _____

(Physician's office stamp is required)

Physical Address:
_____

Parent/Guardian Authorization for Exchange of Information

I hereby request and authorize the exchange of information on the above diagnosis pertaining to my child between school staff of Victor Valley Union School District and (Physician name) _____.
I request Victor Valley Union School District to contact the parent/guardian signing this authorization before contacting the authorizing medical professional _____ (initial here to request). Contact will only be made if the frequency of absences exceeds the number authorized above. I further understand with this verification, I must submit written explanations to verify each absence.

Parent/Guardian Signature _____ Date _____