



POQUOSON CITY PUBLIC SCHOOLS

500 City Hall Avenue, Suite 219

Poquoson, VA 23662

CHRONIC ILLNESS VERIFICATION FORM

Student _____ DOB: ___/___/___ Grade: _____

Forward To (School): _____ Fax Number: _____

Dear Physician:

Your patient is a student enrolled in Poquoson City Public Schools. For our records, please list the chronic illness(s) diagnosed for the student. Also, please check 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 Signature: _____ Date _____

PHYSICIAN VERIFICATION

Chronic Illness/Medical Diagnosis: _____

Expected frequency of episodes _____ and length of absence per episode _____ day(s)/hour(s). (i.e., monthly, 4 times per school year)

Neurological System

- lethargy
- dizziness/unsteadiness
- numbness in extremities
- petit mal seizures
- grand mal seizures
- severe headache
- blurred vision

Genitourinary System

- bladder/kidney infection
- fever

Respiratory System

- weakness/fatigue
- pallor/cyanosis
- continual coughing
- congested airway
- difficulty breathing
- pain

Musculoskeletal System

- pain
- inflammation/swelling
- fever

Gastrointestinal System

- nausea/vomiting
- diarrhea
- constipation
- abdominal pain

Ear, Nose and Throat

- chronic infections
- severe allergies
- severe asthma
- pneumonia/bronchitis

Cardiovascular System

- weakness/dizziness
- pallor/cyanosis
- palpitations
- rapid pulse
- arrhythmia
- pain
- fevers/infections

Integumentary System

- skin lesions
- infections edema
- edema

Additional Comments: _____

To: **Physician's Name:** _____ **Physician's Address:** _____

I hereby request and authorize the exchange of information on the above diagnosis pertaining to my child between designated staff of Poquoson City Public Schools and _____

(physician's name)

I request Poquoson City Public 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. Make-up work must be completed within the designated time according to the Student Handbook.

Parent/Guardian Signature: _____ Date: _____

NOTE: All areas and appropriate symptoms must be completed in order for form to be valid.