Policy © 5-104 & © 5-104.A Students and Students with Chronic Health Conditions – Certification and Program Plan

CERTIFICATION OF STUDENTS WITH CHRONIC HEALTH CONDITIONS

Dear Parent/Guardian,

If your child has a chronic (recurring) medical condition or illness/accident and may have frequent absences, pursuant to A.R.S. § 15-346 they may qualify for a chronic illness form for excused absences verified by a licensed healthcare provider that is treating the student for the qualifying chronic health condition. If you believe your child qualifies for a chronic health condition, please have your licensed healthcare provider complete the Certification of Students with Chronic Health Conditions form and return it to the school's health office. Please read the following information to establish and maintain this authorization**.**

Parent initials are required to acknowledge this information.

☐ Kyrene School District will not accept any Certificate of Chronic Health Condition that is not fully complete even if it is signed by the licensed medical provider.

☐ Your child will not be disqualified from earning course credit because of excessive absences related to their chronic health condition. However, your child will remain obligated to complete all required class work satisfactorily to receive course credit. It is you or your child's responsibility to request homework and return it in a timely fashion when an absence is related to the chronic health condition.

☐ Flexibility will be provided in physical education activity requirements so they may participate in the regular physical education program to the extent that their health permits.

☐ This form does not automatically excuse absences. Parents must call the school on each absence and specify the reason for the absence as "Chronic Illness". Absences that are not related to the diagnosed health problem should be reported as such and are considered separately. Certification of the student's health condition should not be used to excuse absences that are not related to the diagnosed health problem. **Misuse will result in the revocation of the student's participation in the program.**

☐ The student's certification for the chronic illness program takes effect on the date indicated by the doctor. Certification is not retroactive and will not be used to justify absences that occur before that date.

☐ The District Nurse can contact the medical provider to confirm the information or inquire about any questions regarding the medical condition any time with the release of information signed as part of the program.

☐ A student with a chronic health condition must reapply and complete the program's certification process each school year.

☐ A meeting with administration and teachers to discuss the student's accommodations and instructional agreement will be required.

Sincerely,
Kyrene School District

Parent/Guardian Name: _____

Parent(s) Signature_____Date: _____

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Acknowledgment of Disclosure of HIPAA protected information: The student, through their parent/guardian, is hereby requesting the below information for the benefit of the student's education. Disclosure is permitted by 45 C.F.R. §164.502(a).

Student Name: _____ DOB: _____

Student ID #: _____ School: _____ Grade: _____

School Year: _____

Health Care Provider

Since there is no real substitute for the dynamics of classroom instruction, we ask the certified health professional to recommend this option only when it is absolutely necessary.

If you do not anticipate absences exceeding 18 days per school year, student does ***NOT*** qualify for chronic illness status.

Does the student qualify for chronic illness status?

☐ No - Student is **NOT** eligible for chronic illness status

☐ Yes - Student **IS** eligible for chronic illness status -- **Please continue below:**

Diagnosed Chronic Illness or Injury:

Date Diagnosed: _____

Diagnosis due to: Please check

- ☐ Chronic illness – permanent chronic medical certification
- ☐ Injury/Surgery - temporary chronic medical condition
- ☐ Acute illness or medical condition – temporary chronic medical

Identify limitations affecting school activities, including physical education:

Will this condition cause this student to miss > 60 days of school the academic year? If yes, student will qualify for homebound services. ☐ Yes ☐ No

Please estimate **the number of school days** the student is anticipated to miss (> 18 days but < 60 days): ☐

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Please provide a **detailed description** of anticipated office visits, treatments, procedures, therapies, exacerbations, or other medically necessary absences: ***Required**

I hereby certify this student is unable to attend regular classes because of illness, disease or accident, which impacts school attendance, but does not qualify for homebound as defined in ARS 15-761. The chronic health condition shall be certified by a person licensed as a health professional in Arizona under Title 32, Chapter 7, 8, 13, 15, 14, 17 or 25 (a licensed medical doctor, doctor of osteopathy or podiatrist, chiropractor, naturopathic physician, physician assistant or a registered nurse practitioner). I understand I may be contacted by a representative of Kyrene School District if they have additional questions and/or concerns.

I understand that this form will go into effect on the date it is signed and is not retroactive.

By signing below, *I understand that this form must be completed in its entirety to be accepted, and I certify that all the information is true and correct.*

Licensed Health Professional Printed Name: _____

Licensed Health Professional Signature: _____Date:_____

Licensed Title: _____ Phone: _____ Email:_____

Office Name: _____Address: _____

Parents:

Release of Information: I authorize the Kyrene School District Health Staff and the healthcare professional listed above to communicate regarding the information included in this Certificate of Chronic Health Condition to support my student's health needs at school. I understand that this form must be renewed each school year.

I understand that chronic illness status becomes effective on the date this form is signed and is not retroactive. Absences that occurred prior to the signed date are not covered under this agreement.

By signing below, I acknowledge that this form must be fully completed by a licensed healthcare professional, and I certify that the information provided is true and accurate.

Parent Printed Name: _____

Parent Signature: _____ Date: _____