CAVIT School District
Attendance Office
(520) 423-1944

CHRONIC ILLNESS VERIFICATION FORM

Student: _____ ***DOB*** __/__/__ ***Grade:*** _____

Forward to: CAVIT School Attendance Office, FAX (520) 423-1822

Dear Physician,

Your patient is a student enrolled in CAVIT School District. For our records, please list the chronic illness diagnosed for the student 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.

This section must be completed by Physician

_____ __/__/__
Physician signature ***date***
(An attached business card or letterhead is required)

Chronic Illness/Medical Diagnosis: _____

Symptom(s): _____

Expected frequency _____ ***of episodes and length of absence per episode*** _____ ***day(s).***

*examples: 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

Gastrointestinal system
__nausea/vomiting
__diarrhea
__constipation
__abdominal pain

Genitourinary system
__bladder/kidney infection
__fever

Ear, Nose & Throat
__chronic infections
__severe allergies
__severe asthma
__fever
__pneumonia/bronchitis

Additional Comments: _____

_____

Physician's name & address

To: _____
_____
_____

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 attendance staff of the CAVIT School District and
Physician's Name) _____.

I request CAVIT 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 or length of absences exceeds the numbers authorized above. **I further understand with this verification, I must submit written explanations to verify each absence.**

Parent/Guardian Signature: _____ ***Date:*** __/__/__

Boxed areas and appropriate symptoms must be filled in for form to be valid.

Revised 6/13