CHRONIC ILLNESS VERIFICATION FORM (CIVF)

This form allows absences to be excused due to a specific medical condition with the same authority as a medical professional. Below are guidelines for completing the form correctly to establish and maintain this authorization.

1) The Enterprise Elementary School District does not accept any CIVF that does not have the expected frequency of episodes, length of absence, diagnosis, appropriate symptoms listed, Physician's or Medical Group letterhead/business card attached and appropriate signature(s). Please return the form to parent for completion.
2) The school site may fax the CIVF back to the Physician's office to verify the document's authenticity. An administrator or their designee must refuse acceptance of any CIVF found to be fraudulent.
3) Schools will only code absences X (excused) when the parent provides **written** verification listing one or more reasons specified on the form under "Symptom(s)." Phone calls are not acceptable and will be coded with U's (unexcused). After a student reaches 10 excused absences, the parent is subject to receiving communication from the District regarding attendance (SARB).
4) Please monitor the expected frequency and length of episode for absences excused for reasonable compliance with the Physician's guidelines outlined on the form. If there is a concern about the child not making academic progress due to these absences or that the privilege is being misused, the school will contact the student and/or parent to discuss these concerns. For some chronically ill children, alternative educational programs may meet their needs more appropriately.
5) If the site has unresolved concerns, after talking with the student and/or parent, designated Health Services staff will contact the authorizing Physician with specific questions related to the diagnosis and absenteeism. We will refer to the CIVF if the parent initials require contact with them prior to accessing the Physician.
6) Remember, the form expires at the end of the academic year. Obtain a new form annually.

QUESTIONS? Contact your school nurse or Attendance/SARB at *EESD, (530) 224-4100.*

STUDENT AND PHYSICIAN VERIFICATION

_____ _____ _____
Student Name *DOB* *Grade*

RETURN COMPLETED FORM TO
SCHOOL_____ at FAX #: _____.

Dear Physician,

Your patient is a student enrolled in the Enterprise Elementary School District. For your 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 that it is/was received.

Physician Verification: _____ _____ _____
Physician signature *Physician printed name* *Date*

_____
Chronic Illness/Medical Diagnosis of Student Named Above

_____
Symptoms

_____
Anticipated frequency of episodes (monthly, 4x/school year, etc.)

_____
Anticipated Length of absences per episode

PLEASE ATTACH PHYSICIAN'S BUSINESS CARD HERE

PLEASE COMPLETE REVERSE SIDE

SYMPTOMS

Neurological System
__lethargy
__dizziness/unsteadiness
__numbness in extremities
__petit 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

Genitourinary System
__bladder/kidney infection

Cardiovascular System
__weakness/dizziness
__pallor/cyanosis
__palpitations
__rapid pulse
__arrhythmia
__pain
__fever/infections

Gastrointestinal System
__nausea/vomiting
__diarrhea
__constipation
__abdominal pain

PHYSICIAN'S OFFICE TO FAX COMPLETED REPORT TO SCHOOL/FAX IN THE BOX ON REVERSE SIDE.

The parent or guardian must sign the authorization for an exchange of information regarding the diagnosis.

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 Enterprise Elementary School District (EESD) and the aforementioned physician.

I request EESD to inform me, the parent/guardian signing this authorization before contacting the authorizing medical professional._____(initial here to request). This contact will be made only if the frequency or length of absences exceeds the numbers authorized above. **I further understand I must submit a written explanation to verify each absence.**

_____ _____
Parent/Guardian Signature *Date*