Valley View Local Schools
CHRONIC ILLNESS VERIFICATION FORM

Date: _____

Student: _____ DOB: ____/____/____ Grade: _____

Forwarded to: _____ _____
School Fax Number

Dear Physician,

Your patient is a student enrolled in the Valley View Local School District. For our 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 it was received.

Physician Verification	_____ (Physician Signature)	_____ (Printed Name)
	_____ (Date)	

****In order for the school to document the physician's address and phone number please*****
attach a business card or copy of physician's letterhead to this form

Please see next page.

Chronic Illness/Medical Diagnosis: _____

Symptoms: _____

Expected length of absence per episode: _____days. (For example: 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

Respiratory system
___weakness/fatigue
___pallor/cyanosis
___continual coughing
___congested airway
___difficulty breathing
___pain

Gastrointestinal system
___nausea/vomiting
___diarrhea
___constipation
___abdominal pain

Integumentary System
___skin lesions
___infections
___edema

Cardiovascular system
___weakness/dizziness
___pallor/cyanosis
___palpitations
___rapid pulse
___arrhythmia
___pain
___fevers/infections

Ear, Nose & Throat
___chronic infections
___severe allergies
___severe asthma
___fever
___pneumonia/bronchitis

Musculoskeletal system
___ pain
___inflammation/swelling

Genitourinary system
___bladder/kidney infection
___fever

Additional comments: _____

_____

_____

_____

Please see next page for the authorization of exchange of information by parent or guardian.

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 Valley View Local School District and the physician named above.

I request Valley View Local District 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.**

Parent Signature: _____

Date: _____