CDE Chronic Illness Verification Form
T12-478 English Arial Font
Preface Page and 3-Page Form

PREFACE TO DISTRICTS AND COUNTY OFFICES:

Chronic Illness Verification Form (CIVF) Information

The Chronic Illness Form allows parents to excuse absences 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) Holtville Unified 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 V when the parent provides **written** verification listing one or more reasons specified on the form under "Symptom(s)". Phone calls are not acceptable and should be coded with E's unless the 10 days are exhausted, then X's.

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.

For questions, please contact the school counselor at 760-356-2929 or the Student Attendance Officer at Holtville Unified School District 760-356-2974.

STUDENT AND PHYSICIAN VERIFICATION

Student/DOB/Grade: ______________________________________

Forward to: ____________________________ ______________________________
School FAX number

Dear Physician,

Your patient is a student enrolled in Holtville Unified 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 and printed name here Date

Physician's address____

Please attach business card here:

Chronic Illness/Medical Diagnosis____

Symptoms____

Expected frequency of episodes____________
(for example: monthly, 4 times per school year, etc.)

Length of absences per episode____________

On following page, the physician should check the specific symptoms of the child's illness.

SYMPTOMS

Neurological System

__lethargy
(note: translation will go here)

__dizziness/unsteadiness

__numbness in extremities

__petit 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

Genitourinary system

__bladder/kidney infection

Integumentary system

__skin lesions

__infections

__edema

Musculoskeletal system

__pain

__inflammation/swelling

Cardiovascular system

__weakness/dizziness

__pallor/cyanosis

__palpitations

__rapid pulse

__arrhythmia

__pain

__fever/infections

On the next page, 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 Holtville Unified School District and the physician named above.

I request Holtville Unified School 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: ______________________________________