

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) San Juan Unified School District does not accept any CIVF that does not have the expected frequency of episodes, length of absence, diagnosis, appropriate symptoms listed, Provider'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 Provider'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 Provider'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 Provider 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 San Juan Unified School District Attendance Improvement Program/SARB at 916-979- 8604.



San Juan Unified School District

Office of Student Support Services

Attendance Improvement Program
3700 Garfield, Carmichael, CA 95608
Attendance Improvement Program: 916-979-8604

CHRONIC ILLNESS VERIFICATION FORM

STUDENT/DOB/GRADE:

Please return this form to your school Attendance Office.

Dear Primary/Specialty Care Provider,

Your patient is a student enrolled in San Juan Unified 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.

**Primary/Specialty Care
Provider Verification**

Primary/Specialty Care Provider's signature: _____

Printed name: _____

Address: _____

Date: _____

(Copy of 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

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

Genitourinary system

bladder/kidney infection
fever

Ear, Nose & Throat

chronic infections
severe allergies
severe asthma
fever
pneumonia/bronchitis

Additional Comments: _____

**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 Health Services designated staff of the San Juan Unified School District and the Care Provider named above.

I request San Juan Unified School District to contact the parent/guardian signing this authorization before contacting the authorizing Care Provider. (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 with this verification, I must submit written explanations to verify each absence.

Parent/Guardian Signature and Date:

ALL

BOXED

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