Chronic Illness Verification Form (CIVF) Information

The Chronic Illness Form allows parents/guardians 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) SJUSD 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/guardian 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/guardian 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/guardian 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/guardian, 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 your school nurse or Attendance Improvement Program/SARB (916) 979-8604.
San Juan Unified School District  
Admissions & Family Services  
Attendance Improvement Program/S.A.R.B.  
3700 Garfield Avenue, Carmichael, CA 95608  
TEL: 916-979-8604      FAX: to your student’s school

CHRONIC ILLNESS VERIFICATION FORM

STUDENT/DOB/GRADE: ____________________

Forward to: ________________________________

School Fax Number _________________________

Dear Physician,

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/guardian 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’s Name & Address

Physician signature and Printed name __________________________ date ____________

(Copy of business card or letterhead is required)

Physician name & address

Chronic Illness/Medical Diagnosis: ________________________________

Symptom(s):

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

*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

Integumentary system
__skin lesions
__infections
__edema

Musculoskeletal system
__pain
__inflammation/swelling

Additional Comments: ____________________________________________________________________________________

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

I hereby request and authorize the exchange of information on the above diagnosis pertaining to my child between designated Health staff of the San Juan Unified School District and the physician named above.

I request San Juan 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/Guardian Authorization for Exchange of Information

Parent/Guardian Signature and date: ________________________________

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