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) 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 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 your school nurse or Attendance Improvement Program/SARB (916) 979-8604.
San Juan Unified School District
Pupil Personnel Services
Attendance Improvement Program/S.A.R.B.
3738 Walnut Avenue, Carmichael, CA 95608
TEL: 916-979-8604    FAX: 971-7347

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 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 signature and Printed name                   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).

*For example: monthly, 4 times per school year, etc.

Physician Verification

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

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

Parent/Guardian Signature and date:

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 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

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