Chronic Illness Verification Form (CIVF)

The Chronic Illness Verification Form (CIVF) can be used by the parent/guardian 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) The CIVF must be completed in its entirety. Incomplete forms will not be accepted and will be returned to the parent/guardian for completion.

2) Completion of this form authorizes the licensed credentialed school nurse (LCRN) to contact the physician's office to verify authenticity and/or obtain clarification related to the student's diagnosis and symptoms as applicable to the CIVF.

3) The CIVF can be completed anytime throughout the school year and utilized to excuse an absence **only when it is related to the exact diagnosis and symptoms** as documented in the CIVF.

4) The form expires at the end of the academic year. For questions, please contact Springs LCRN at (951) 234-3776.

El padre/tutor puede utilizar el Formulario de Verificación de Enfermedad Crónica (CIVF) para justificar ausencias debido a un específico condición médica con la misma autoridad que un profesional médico. A continuación se detallan las pautas para completar el formulario correctamente para establecer y mantener esta autorización.

1) El CIVF debe completarse en su totalidad. No se aceptarán formularios incompletos y se devolverán al padre/tutor para que los complete.

2) Completar este formulario autoriza a la enfermera escolar acreditada y con licencia (LCRN) a comunicarse con el consultorio del médico para verificar la autenticidad y/u obtener aclaraciones relacionadas con el diagnóstico y los síntomas del estudiante según corresponda al CIVF.

3) El CIVF se puede completar en cualquier momento durante el año escolar y utilizarse para justificar una ausencia. **sólo cuando está relacionado con el diagnóstico y los síntomas exactos** como se documenta en el CIVF.

4) El formulario caduca al final del año académico. Si tiene preguntas, comuníquese con Springs LCRN al (951) 234-3776.

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STUDENT AND PHYSICIAN VERIFICATION

Student Name: _____ DOB: _____ Grade: _____

School Site: _____

Forward to: Tony Escalante/ Jessica Chadwell (Licensed Credentialed School Nurse) 951-489-0494 (FAX number) School.nurse@springscs.org (Email)

Dear Physician,
Your patient is a student enrolled in Springs Charter Schools. For the records, please list the chronic illness diagnosed for the student and 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 and must be renewed annually.

Physician Verification:

Physician (printed): _____ License Number: _____

Physician Signature: _____ Date: _____

Hospital/Office Address: _____

Phone Number: _____ Fax: _____

Please attach business card/stamp here:

Chronic Illness/Medical Diagnosis _____

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

Length of absences per episode _____

On the following page, the physician should check the specific symptoms of the child's illness that would excuse the student from attending school.

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SYMPTOMS

Neurological System

__lethargy

__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

Integumentary System

__skin lesions

__infections

__edema

Musculoskeletal system

__pain

__inflammation/swelling

Cardiovascular System

__weakness/dizziness

__pallor/cyanosis

__palpitations

__rapid pulse

__arrhythmia

__pain

__fever/infections

Genitourinary System

__bladder/kidney infection

Additional Symptoms _____

_____

_____

On the next page, the parent or guardian must sign the authorization for an exchange of information regarding the diagnosis.
En la página siguiente, el padre o tutor deberá firmar la autorización para el intercambio de información sobre el diagnóstico.

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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 Springs Charter Schools and the physician named above.

I request Springs Charter Schools 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 that I must submit written explanations to verify each absence.**

Parent Name (Print): _____ Date: _____

Parent Signature: _____ Date: _____

AUTORIZACIÓN DE PADRE/TUTOR

Por la presente solicito y autorizo el intercambio de información sobre el diagnóstico anterior relacionado con mi hijo entre el personal designado por Health de Springs Charter Schools y el médico mencionado anteriormente.

Solicito a Springs Charter Schools que me informe a mí, el padre/tutor firmando esta autorización, antes de comunicarse con el profesional médico autorizado _____ (ponga sus iniciales aquí para solicitar).

Este contacto sólo se realizará si la frecuencia o duración de las ausencias excede los números autorizados anteriormente. **Además, entiendo que debo presentar explicaciones por escrito para verificar cada ausencia.**

Nombre del padre (imprimir): _____ Fecha: _____

Firma de los padres: _____ Fecha: _____