Chronic Illness Verification Form (CIVF) Information

To: _____ Date: _____

From: _____

Campus: _____ Phone: _____

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. EDUPRIZE SCHOOLS does not accept any CIVF that does not have a Certificate of Chronic Health Condition attached. This Certificate of Chronic Health Condition needs to have the following: frequency of episodes, length of absence, diagnosis, appropriate symptoms listed, Physician's or Medical Group letterhead/business card attached and appropriate physician signature(s).

2. The school site may fax the CIVF or Certificate of Chronic Health Condition back to the Physician's office to verify the document's authenticity. An administrator or their designee must refuse acceptance of any CIVF or Certificate of Chronic Health Condition if found to be fraudulent.

3. Before the CIVF is activated, a team will meet to clarify the Individual Health Care Plan. The team consists of the parent(s) or guardians, Assistant Director, Health Aide and Health Care Coordinator.

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 campus 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. Please ensure you have signed the authorization form.

6. Remember, the form expires at the end of the academic year. Obtain a new form annually.

For questions, please contact our health office.

Certificate of Chronic Health Condition for School Year 20___ - 20___

Student Name: _____ Date: _____

Campus: _____ Grade: _____ Student #: _____

Number of school days absent this year: _____ as of this date: _____

I authorize EDUPRIZE SCHOOLS and my Health Care Provider to exchange information provided in this Certificate of Chronic Health Condition.

_____	_____	_____
Parent Name	Parent Signature	Date

Health Care Provider – Please Review These Instructions Before Completing This Form

The purpose of this form is to enable a health care provider to certify that an EDUPRIZE SCHOOLS student qualifies as a student with a chronic health condition.

Certification is appropriate only if the student will be unable to attend school frequently or for substantial periods due to illness, disease, injury (accident), or pregnancy complications. Certification is not appropriate if the health condition is not sufficiently debilitating to prevent the student from attending school.

By state law, this certification may be provided only by a licensed medical doctor, osteopathic physician, podiatrist, naturopathic physician, chiropractor, physician's assistant, or registered nurse practitioner.

HEALTH CARE PROVIDER – PLEASE COMPLETE THE FOLLOWING:

Student's diagnosed health condition: _____

Is the student's health condition active currently? ▢ No ▢ Yes

Comment: _____

Is the student currently able to attend school? ▢ No ▢ Yes

Yes with these accommodations: _____

Is the student currently able to participate in physical activity? ▢ No ▢ Yes

Comment: _____

How many days do you anticipate the student will miss each semester?

▢ Less than 9 Days ▢ 9-15 Days ▢ 16-20 Days ▢ 20+ Days

If you are able, please indicate when the student's health condition is expected to end: _____

_____	_____	
Health Care Provider Name Printed	Licensing Title	
_____	_____	_____
Health Care Provider Signature	Date	Phone Number
_____	_____	
Business Name	Address	

HEALTH CARE PROVIDER – PLEASE COMPLETE THE FOLLOWING:

Student Name: _____ Date: _____

SYMPTOMS

Neurological System

- ☐ Lethargy
- ☐ Dizziness/Unsteadiness
- ☐ Numbness in extremities
- ☐ Petit mal seizures
- ☐ Severe headache
- ☐ Blurred vision
- ☐ Other:_____

Respiratory System

- ☐ Weakness/fatigue
- ☐ Pallor/cyanosis
- ☐ Continual coughing
- ☐ Congested airway
- ☐ Difficulty breathing
- ☐ Pain
- ☐ Other:_____

Musculoskeletal System

- ☐ Pain
- ☐ Inflammation/swelling
- ☐ Other:_____

Genitourinary System

- ☐ Bladder/kidney infection
- ☐ Other:_____

Integumentary System

- ☐ Skin Lesions
- ☐ Infections
- ☐ Edema
- ☐ Other:_____

Cardiovascular System

- ☐ Weakness/dizziness
- ☐ Pallor/cyanosis
- ☐ Palpitations
- ☐ Rapid pulse
- ☐ Arrhythmia
- ☐ Pain
- ☐ Fever/infections
- ☐ Other:_____

Gastrointestinal System

- ☐ Nausea/vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Abdominal pain
- ☐ Other:_____

_____
Health Care Provider Name

_____ _____
Health Care Provider Signature Date