Paso Robles Joint Unified School District
800 Niblick Road/PO Box 700
Paso Robles CA 93447
805-769-1000 / FAX 805-237-3339

Chronic Illness Verification Form

Name of Student	DOB	Grade
School Site	FAX	

Dear Physician:

Your patient is a student enrolled in Paso Robles Joint 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.

Chronic Illness/Medical Diagnosis: _____

Symptoms:

Neurological system
__Lethargy
__Dizziness
__Numbness in extremities
__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
__Rapid pulse
__Arrhythmia
__Pain
__Fever/infections

Genitourinary system
__Bladder/kidney infection
__Fever

Musculoskeletal system
__Pain
__Inflammation/swelling

Ear, Nose & Throat
__Chronic infections
__Severe allergies
__Severe asthma
__Fever
__Pneumonia/bronchitis

Additional Comments: _____

_____

Expected frequency of episode is _____ and expected length of absence per episode is _____ .

Example: Weekly/twice monthly

Physician Verification

Signature: _____

Printed Name: _____

ATTACH COPY OF BUSINESS CARD OR LETTERHEAD TO THIS DOCUMENT

Parent/Guardian Authorization for Exchange of Information

I request Paso Robles Joint Unified School District to contact 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 with this verification, I must submit written explanations to verify each absence.

Parent/Guardian Authorized Signature: _____

Date: _____