Student Support Services
1130 Fifth Avenue, Chula Vista CA 91911
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CHRONIC ILLNESS VERIFICATION (CIV) FORM

The Chronic Illness Verification (CIV) 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) Sweetwater Union High School District (SUHSD) will not accept a CIV form that does not have the expected frequency of episodes, length of absence, diagnosis, appropriate symptoms listed, and Physician's or Medical Group stamp or business card attached with appropriate signature(s).

2) The school site may fax the CIV form back to the Physician's office to verify the document's authenticity. An administrator or their designee will refuse acceptance of any CIV form found to be fraudulent.

3) Schools will only code absences 'Absent-Doctor's Note' (AD) when the parent/guardian provides verification that lists one or more reasons specified on the form under "Symptoms". Absences must be excused within the 30 calendar days. If no verification is provided, then 'Absent-Unverified' (AU) will be coded.

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 CIV form if the parent/guardian initials require contact with them prior to accessing the Physician.

6) The form expires at the end of the academic year; therefore, you must obtain a new form annually. Contact the nurse with individual questions.

7) For questions, contact your school nurse or attendance coordinator at your child's school.

PARENT/GUARDIAN AUTHORIZATION

I hereby request and authorize the exchange of information on the medical diagnosis pertaining to my child between health designated staff of the Sweetwater Union High School District and the Physician listed.

I request Sweetwater Union High School District employees 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.

Parent/Guardian Name: ____

Parent/Guardian Signature: ______________________________________ Date: ________________________

STUDENT AND PHYSICIAN VERIFICATION

Student: ______________________ DOB: ______________ Grade: ________

Dear Physician,

Your patient is a student enrolled in the Sweetwater Union High 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 student to stay home from school. This will allow the parent/guardian to verify the illness by listing the symptoms designated below without bringing the student to your office for an examination. This document expires at the end of the academic year that it is/was received.

Chronic Illness/Medical Diagnosis: ______________________________

Expected frequency of episodes: __________
(i.e., monthly, 4x per school year)

Length of absences per episode: __________
(i.e., half day, all day)

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

Cardiovascular System

- — Weakness/dizziness
- — Pallor/cyanosis
- — Rapid pulse
- — Arrhythmia
- — Pain
- — Fever/infection

Gastrointestinal System

- — Nausea/vomiting
- — Diarrhea
- — Constipation
- — Abdominal pain

Integumentary System

- — Skin lesions
- — Infections
- — Edema

Musculoskeletal System

- — Pain
- — Inflammation/swelling

Genitourinary System

- — Bladder/kidney infection

Other Symptoms:

____
____
____

Please list any other important information regarding the student's medical condition that may impact their attendance: ______________________________
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Physician Signature: ______________________ Date: ______________
(must be a California licensed practitioner, i.e., MD, DO, PA, NP)

PLEASE STAMP OR ATTACH A BUSINESS CARD.