**Wilson County Schools**

Chronic Illness Verification Form (CIVF) Information

The Chronic Illness Form allows doctors to excuse absences due to a specific medical condition. Below are guidelines for completing the form correctly to establish and maintain this authorization.

1. Wilson County Schools 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 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 AE when the parent provides **written** verification (email) listing one or more reasons specified on the form under “Symptom(s)”. This written verification will need to be provided to the school nurse and attendance person each day that the student is absent by 9:00 a.m.
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. When a child misses 10 and 15 days within a school year the attending Physician will be notified and the physician will provide documentation to the school for the CIVF to remain active.
6. If the school 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.
7. Remember, the form expires at the end of the academic year. Obtain a new form annually.

For questions, please contact your school nurse or SIS/Registrar person.

**STUDENT AND PHYSICIAN VERIFICATION**

Student/DOB/Grade: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Forward to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 School FAX number

Dear Physician,

Your patient is a student enrolled in Wilson County Schools. From your 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 an email to the school the symptoms designated below, without bringing the child to your office for an examination. We also require the parent to notify your office when the child is absent and not attending school. This document expires at the end of the academic year that it is/was received.

Physician Verification:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

 Physician signature and printed name here Date

Physician’s address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chronic Illness/Medical Diagnosis\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expected frequency of episodes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Example: monthly, 4 times per school year, etc.)

Expected length of episodes circle one: a) hour or two, b) half-day, or c) full-day.

***The Physician should check the given symptoms.***

**SYMPTOMS**

|  |  |
| --- | --- |
| Respiratory system  | Gastrointestinal system |
| \_\_weakness/fatigue   | \_\_nausea/vomiting |
| \_\_pallor/cyanosis   | \_\_diarrhea  |
| \_\_continual coughing   | \_\_constipation |
| \_\_congested airway   | \_\_abdominal pain  |
| \_\_difficulty breathing   |  |
| \_\_pain |  |
|  |  |
| Cardiovascular system  | Genitourinary system  |
| \_\_weakness/dizziness  | \_\_bladder/kidney infection |
| \_\_pallor/cyanosis   |  |
| \_\_palpitations |  |
| \_\_rapid pulse |  |
| \_\_arrhythmia |  |
| \_\_pain |  |
| \_\_fever/infections |  |

 Neurological System

\_\_lethargy

 *(Note: translation will go here)*

\_\_dizziness/unsteadiness

\_\_numbness in extremities

\_\_petit mal seizures

\_\_severe headache

\_\_blurred vision

Integumentary system

\_\_skin lesions

\_\_infections

\_\_edema

\_\_musculoskeletal system

\_\_pain

\_\_inflammation/swelling

Additional information \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***An Individual Health Plan (IHP) must be completed, signed by parent and physician, and returned to the school.***

***On the next page, the parent or guardian must sign the authorization for an exchange of information regarding the diagnosis.***

**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 Wilson County Schools and the physician named above.

**I further understand I must submit written/email explanations to verify each absence.**

Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent signature: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**School Procedure Page**

1. If a chronic letter is brought to the school it must be shared with both the Nurse, School Counselor and Registrar. The Nurse will then hand out the chronic packet. At this time the correct IHP will be placed with the packet and given to the parent. The completed packed must be returned to the Nurse who will share it with the Registrar and School Counselor.
2. We will begin this process starting at the beginning of the 2017-2018 school year. However, all students that currently have a chronic illness letter on file should receive a copy of the packet prior to the end of this school year. This allows the parent/doctor time to get the paperwork completed prior to school starting.
3. Please note that the entire packet must be returned to the school for acceptance and signed only by a doctor.