Hampton City Schools
One Franklin Street
Hampton, Virginia 23669

Chronic Illness Verification Form

Student: _____ BD: ___/___/_____ Grade: _____

Forward To (School) _____ Fax Number: _____

Dear Physician:

Your patient is a student enrolled in *Hampton City Schools*. For our records, please list the chronic illness(s) 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.

*Physician Signature: _____ Date: _____

***Note: An attached business card or letterhead is required.**

PHYSICIAN VERIFICATION

Chronic Illness/Medical Diagnosis: _____

Symptom(s); _____

Expected frequency of episodes ____ and length of absence per episode ____ day(s). (i.e., monthly, 4 times per school year)

Neurological System
_lethargy
_dizziness/unsteadiness
_numbness in extremities
_petit mal seizures
_grand mal seizures
_severe headache
_blurred vision

Respiratory System
_weakness/fatigue
_pallor/cyanosis
_continual coughing
_congested airway
_difficult breathing
_pain

Gastrointestinal System
_nausea/vomiting
_diarrhea
_constipation
_congested airway
_abdominal pain

Cardiovascular System
_weakness/dizziness
_pallor/cyanosis
_palpitations
_rapid pulse
_arrhythmia
_pain
_fevers/infections

Genitourinary System
_bladder/kidney infection
_fever

Musculoskelotal System
_pain
_inflammation/swelling
_fever

Ear, Nose, and Throat
_chronic infections
_severe allergies
_severe asthma
_pneumonia/bronchitis

Integumentary System
_skin lesions
_infections edema
_edema

Additional Comments: _____

To: Physician's Name: _____ Physician's Address: _____

I hereby request and authorize the exchange of information on the above diagnosis pertaining to my child between designated staff of *Hampton City Schools* and _____.
(Physician's Name)

I request *Hampton City Schools* 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 Signature: _____ Date: _____