San Luis Obispo County Office of Education
3350 Education Drive, San Luis Obispo, CA 93405
Attn. School Nurse (Holly Stoner/Fran Coughlin)
Office: (805) 593-3134
Confidential Fax: (805) 546-0646

CHRONIC ILLNESS VERIFICATION FORM

____ ____________ ________
Name of Student DOB Grade

____ __(805) 546-0646__________
School Site FAX

Dear Physician,

Your patient is a student enrolled in a San Luis Obispo County Office of Education (SLOCOE) School. For the purpose of verifying chronic absenteeism linked to a significant health condition, please list the chronic illness/medical diagnosis for this student. Also, please check or list symptoms that may not warrant an office visit, but would require the child to stay home from school. If there are no symptoms connected to a significant health condition that would warrant missed school days, please indicate that as well. This form can be directly faxed back to the school nurse at the number provided above. This document expires at the end of the academic school year it was received.

Chronic Illness/Medical Diagnosis:

Symptoms:

Neurological system
__Lethargy
__Dizziness
__Numbness in extremities
__Seizures
__Severe headache
__Blurred vision

Integumentary system
__Skin lesions
__Infections
__Edema

Musculoskeletal system
__Pain
__Inflammation/swelling

Respiratory system
__Weakness/fatigue
__Pallor/cyanosis
__Continual coughing
__Congested Airway
__Difficulty Breathing
__Pain

Cardiovascular system
__Weakness/dizziness
__Pallor/cyanosis
__Rapid pulse
__Arrhythmia
__Pain
__Fever/infections

Gastrointestinal system
__Nausea/vomiting
__Diarrhea
__Constipation
__Abdominal pain

Genitourinary system
__Bladder/kidney infection
__Fever

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's Signature: ____

Physician's Printed Name: ____

Physician's Office Phone Number: ____

PARENT/GUARDIAN AUTHORIZATION FOR EXCHANGE OF INFORMATION

I hereby request and authorize the above named physician to release and exchange medical/psychological information regarding my child, named above, with a representative of the nursing staff from the SLOCOE. I understand this information will be used for the purposes of verifying my child's absences and/or establishing appropriate educational support for my child.

Parent/Guardian Authorized Signature: ______________________________ Date: ____________