St. Johns County School District
40 Orange Street
St. Augustine, FL 32084
Health Services: 904-547-7693

CHRONIC ILLNESS VERIFICATION FORM

Please return this form to your school Attendance Office

_____ _____ _____
NAME OF STUDENT DATE OF BIRTH GRADE/SCHOOL

Dear Primary/Specialty Care Provider,

Your patient is a student enrolled in St. Johns County School District. 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 document expires at the end of the academic school year it was received.

Chronic Illness/Medical Diagnosis: _____

Symptom(s):

Neurological System
___Lethargy
___Dizziness/unsteadiness
___Numbness in extremities
___Petit mal seizures
___Grand mal 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
___Palpitations
___Rapid pulse
___Arrhythmia
___Pain
___Fevers/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 required:_____
(A physician with a current license to practice medicine or osteopathy in this state)

Printed Name:_____Date:_____

Address:_____Phone:_____

PARENT/GUARDIAN AUTHORIZATION FOR EXCHANGE OF INFORMATION

I hereby request and authorize the exchange of information on the above diagnosis pertaining to my child between Health Services designated staff of the St. Johns County School District and the Care Provider named above.

Parent/Guardian Authorized Signature_____ Date_____