Santa Barbara Unified
Every child, every chance, every day.

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SBUnified.org

CHRONIC ILLNESS VERIFICATION FORM

Date: _____

Student: _____ DOB: _____/_____/_____ Grade:_____

Forwarded to: _____ _____
School Fax Number

Dear Medical Provider,
Your patient is a student enrolled in the Santa Barbara Unified 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 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.

Medical Provider Verification –
Licensed to practice medicine in the State of California

_____ _____
Medical Provider signature and printed name here Date

_____
Medical Provider address

(Please attached your business card or letterhead)

Chronic illness/Medical Diagnosis: _____

Symptoms:_____

Expected length of absence per episode: _____days. *(for example: monthly, 4 times per school year, etc.)*

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: _____

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 the Santa Barbara Unified School District and the physician named above.

I request Santa Barbara Unified School District 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. **I further understand I must submit written explanations to verify each absence.**

Parent signature: _____

Date:_____