Hampton City Schools
One Franklin Street
Hampton, Virginia 23669

Chronic Illness Verification Form

Date: ______________________

To the Parent/Guardian of: _________________________________

Virginia Law and Hampton City Schools require students to attend school daily in order to receive the maximum benefit from the instructional program, as well as develop habits of punctuality, self-discipline, and responsibility. According to Hampton City Schools Attendance Policy JED, students may earn excused absences as a result of illness. Medical documentation is required to verify chronic or extended illnesses. If a student has a chronic or recurring illness, the school division requires a parent/guardian and appropriate physicians to complete this Chronic/Extended Illness Verification Form.

Our records indicate that your child has accrued ___________ absences related to illness. **Documentation from a physician is now required. Please complete the information below and have your child's physician(s) provide the information on the back.**

PARENT/GUARDIAN AUTHORIZATION FOR RELEASE AND/OR EXCHANGE OF INFORMATION

Student Name: __________________________ **Student Date of Birth:** _________________

Parent/Guardian Name: ____

I hereby authorize the following provider(s) (doctor, hospital, etc.) **to release and/or exchange information with Hampton City Schools:** ___________________________________

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This authorization is valid for one year. I understand that I may revoke this authorization at any time by submitting written notice of my consent. I recognize that these records, once received by the school district, may not be protected by the HIPAA Privacy Rule, but will become education records protected by the Family Educational Rights and Privacy Act (FERPA). I also have been informed that this information will be maintained in my student's Cumulative Health Record. I understand that if I refuse to sign, such refusal will result in this information not being utilized for attendance purposes.

Parent/Guardian Signature and Date: ____

Student Signature *(if applicable)* **and Date:** ____

School Nurse Signature and Date: ____

PHYSICIAN VERIFICATION

INFORMATION BELOW MUST BE COMPLETED BY THE DOCTOR(S) ONLY
What is the nature and extent of the illness that would cause the student to have absences from school? *(Medical, mental health, disabilities, etc.)*

Is there a diagnosis of a long-term illness at this time? Yes ____ No _____

If Yes, please include the diagnosis: ____

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What is the treatment plan for the on-going illness or diagnosis? *(Please attach any orders that will assist in keeping the student in school, i.e. medication, accommodations, etc.)*

How many days of the week or month do you anticipate the illness or diagnosis will be the direct cause of the student's absenteeism? _______________ Comments below:

Doctor's Name and Phone #: ____

(Used for contacting the doctor should the school have questions related to absences.)

Physician's Signature/Date: ____
Physician's Stamp Required

THIS FORM WILL BE KEPT IN THE STUDENT'S SCHOOL RECORD AND MUST BE RENEWED AT THE BEGINNING OF EACH SCHOOL YEAR.