EDUPRIZE SCHOOLS

Gilbert Campus
580 W. Melody Ave.
Gilbert, AZ 85233
480-813-9537
480-813-6742 fax

Queen Creek Campus
4567 W. Roberts Rd.
Queen Creek, AZ 85142
480-888-1610
480-888-1655 fax

Chronic Illness Verification Form (CIVF) Information

To: _____ Date: _____

From: _____

Campus: _____ Phone: _____

The Chronic Illness Form allows parents to excuse absences due to a specific medical condition with the same authority as a medical professional. Below are guidelines for completing the form correctly to establish and maintain this authorization.

1. EDUPRIZE SCHOOLS does not accept any CIVF that does not have a Certificate of Chronic Health Condition attached. This Certificate of Chronic Health Condition needs to have the following: frequency of episodes, length of absence, diagnosis, appropriate symptoms listed, Physician's or Medical Group letterhead/business card attached and appropriate physician signature(s).

2. The school site may fax the CIVF or Certificate of Chronic Health Condition back to the Physician's office to verify the document's authenticity. An administrator or their designee must refuse acceptance of any CIVF or Certificate of Chronic Health Condition if found to be fraudulent.

3. Before the CIVF is activated, a team will meet to clarify the Individual Health Care Plan. The team consists of the parent(s) or guardians, Assistant Director, Health Aide and Health Care Coordinator.

4. Please monitor the expected frequency and length of episode for absences excused for reasonable compliance with the physician's guidelines outlined on the form. If there is a concern about the child not making academic progress due to these absences or that the privilege is being misused, the school will contact the student and/or parent to discuss these concerns. For some chronically ill children, alternative educational programs may meet their needs more appropriately.

5. If the campus has unresolved concerns, after talking with the student and/or parent, designated Health Services staff will contact the authorizing physician with specific questions related to the diagnosis and absenteeism. We will refer to the CIVF if the parent initials require contact with them prior to accessing the physician. Please ensure you have signed the authorization form.

6. Remember, the form expires at the end of the academic year. Obtain a new form annually.

For questions, please contact our health office.

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Certificate of Chronic Health Condition

for School Year 20____ - 20____

Student Name: _____ Date: _____

School: _____ Grade: _____ Student #: _____

Number of school days absent this year: _____ as of this date: _____

I authorize EDUPRIZE SCHOOLS and my Health Care Provider to exchange information provided in this Certificate of Chronic Health Condition.

_____ _____ _____
Parent Name | Parent Signature | Date

Health Care Provider – Please Review These Instructions Before Completing This Form

The purpose of this form is to enable a health care provider to certify that an EDUPRIZE SCHOOLS student qualifies as a student with a chronic health condition.

Certification is appropriate only if the student will be unable to attend school frequently or for substantial periods due to illness, disease, injury (accident), or pregnancy complications. Certification is not appropriate if the health condition is not sufficiently debilitating to prevent the student from attending school.

By state law, this certification may be provided only by a licensed medical doctor, osteopathic physician, podiatrist, naturopathic physician, chiropractor, physician's assistant, or registered nurse practitioner.

HEALTH CARE PROVIDER – PLEASE COMPLETE THE FOLLOWING:

Student's diagnosed health condition: _____

Is the student's health condition active currently? ____no / ____yes

Comment: _____

Is the student currently able to attend school? ____no / ____yes

____yes with these accommodations: _____

Is the student currently able to participate in physical activity? ____no / ____yes

Comment: _____

Do you expect the student to miss more than 9 school days per semester? ____no / ____yes

Is you are able, please indicate when the student's health condition is expected to end: _____

_____

_____ _____
Health Care Provider Name Printed | Licensing Title

_____ _____ _____
Health Care Provider Signature | Date | Phone Number

_____ _____
Business Name | Address

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To be completed by the treating Health Care Provider:

Student Name: _____ Date: _____

SYMPTOMS

Neurological System

___ Lethargy

___ Dizziness/unsteadiness

___ Numbness in extremities

___ Petit mal seizures

___ Severe headache

___ Blurred Vision

___Other: _____

Respiratory System

___ Weakness/fatigue

___ Pallor/cyanosis

___ Continual Coughing

___ Congested airway

___ Difficulty Breathing

___ Pain

___ Other: _____

Gastrointestinal System

___ Nausea/vomiting

___ Diarrhea

___ Constipation

___ Abdominal pain

___ Other: _____

Integumentary System

___ Skin Lessons

___ Infections

___ Edema

___ Other: _____

Cardiovascular System

___ Weakness/dizziness

___ Pallor/cyanosis

___ Palpitations

___ Rapid pulse

___ Arrhythmia

___ Pain

___ Fever/infections

___ Other: _____

Genitourinary System

___ Bladder/kidney infection

___Other: _____

Musculoskeletal System

___ Pain

___ Inflammation/swelling

___ Other: _____

_____ Health Care Provider Name

_____ Health Care Provider Signature

_____ Date