BISD

Chronic Illness Verification Letter

The Chronic Illness Form (CIF) 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) **Bastrop ISD** does not accept any CIF that does not list the expected frequency of episodes, length of absence, diagnosis, appropriate symptoms listed, Physician's or Medical Group letterhead/prescription attached, and appropriate signature(s).
2) The school site may contact the Physician's office to verify the document's authenticity. An administrator or their designee will not honor any CIF found to be fraudulent.
3) 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 or homebound services may meet their needs more appropriately.
4) If the site 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.
5) A CIF expires at the end of each academic year, and a new one must be complete and filed with the child's school for each academic year in which the child's diagnosis continues to impact his/her ability to maintain 90% on-campus attendance, in compliance with state law.

STUDENT AND PHYSICIAN VERIFICATION

Student_____ DOB:_____ Grade:_____

Submit to:_____ _____

School FAX Number or Email Address

Dear Physician,

Your patient is a student enrolled in Bastrop ISD. 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 that it is/was received.

_____ _____ _____

Physician Printed Name Physician Signature Date

Address_____

Chronic Illness/Medical Diagnosis_____

Symptoms_____

Expected frequency of episodes_____ Expected length of absences per episode_____
(for example: monthly, 4 times per school year, etc.)

Please attach signed Business Letterhead affirming the Physician's office completed this form.

SYMPTOMS

Neurological System

__Lethargy

__Dizziness/Unsteadiness

__Numbness in Extremities

__Petit Mal Seizures

__Severe Headache

Respiratory System

__Weakness/Fatigue

__Pallor/Cyanosis

__Continual Coughing

__Congested Airway

__Difficulty Breathing

__Pain

Gastrointestinal System

__Nausea/Vomiting

__Diarrhea

__Constipation

__Abdominal Pain

Integumentary System

__Skin Lesions

__Infections

__Edema

Musculoskeletal System

__Pain

__Inflammation/Swelling

Cardiovascular System

__Weakness/Dizziness

__Pallor/Cyanosis

__Palpitations

__Rapid Pulse

__Arrhythmia

__Pain

__ Fever/Infections

Genitourinary System

__Bladder/Kidney Infection

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 **Bastrop ISD** and the physician named above.

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:_____

For Office Use Only:

This CIF is for the 20____-20____ school year and expires on _____, 20_____