

Buena Vista City Public Schools Chronic Condition Documentation

Office Use

Start Date _____
End Date _____
Staff Notice _____
By Whom _____

To: Parent/Guardian of _____ Grade _____

From: _____, District Nurse
Phone: _____ Fax: _____

Buena Vista City Public Schools will authorize absences resulting from a **chronic medical condition, extended illness, treatment or therapy** once this chronic condition documentation is on file with the school. Your student's Health Care Provider must complete the medical information section below before returning this form to the health office. Backdating the start date beyond one month is not acceptable.

When reporting an absence, indicate the absence is due to the chronic condition listed below. In accordance with attendance regulations, absences for any other reason must be identified as such.

Your signature also authorizes a release of information between the District Nurse and Health Care Provider regarding this student's chronic health issue and how it impacts school attendance. The District Nurse may request updated information at any point during the school year.

Parent/Guardian signature: _____ Date: _____

Daytime phone number: _____ Alternate Number: _____

cc: School Counselor
Administrative Assistant

Health Care Provider:

This form provides documentation regarding this student's chronic or extended health condition that may cause absences from school. Complete the form below to provide the necessary documentation.

MEDICAL INFORMATION

Information will be part of the student's confidential health record.

Diagnosis that may affect student attendance _____

Start date this diagnosis affected school attendance _____ End date _____

Please be specific in your description of how you think this diagnosis may affect school attendance:

Estimated frequency of absences from school, including appointments: _____ per Week / Month (circle one)

List school-related restrictions:

Signature of Healthcare Provider _____ Printed Name _____

Date: _____ Office Phone: _____ Office Fax: _____