Chronic Illness/Ongoing Treatment Verification Form

This form is to be used to verify that the named student has a long-term chronic health issue requiring frequent healthcare visits, monthly orthodontic appointments, therapy sessions, treatment, etc. that may result in frequent absences and/or tardies. This form must be on file at the school. One form per condition. A regular healthcare provider note will be required for each absence/tardy due to a visit/appointment.

Student Last Name: _____ First Name _____ MI _____

DOB:_____/_____/_____ School: _____ Grade: _____

Dear Healthcare Provider,

Your patient is a student enrolled in Lewis County Schools. For our records, please list the chronic illness/condition diagnosed for this student or other reasons this child may need to be excused from school for other physical, mental health, and/or therapeutic needs. Lewis County Schools' policy allows ten (10) healthcare provider excuses, but special consideration will be given for absences/tardies exceeding the allowed number if this form is on file with the school. Even with this form, each time your patient visits your office; please provide them with a regular excuse. This document expires at the end of the academic year it was received and will remain on file as an excuse along with other excuse documentation provided on visits to your office and/or any place providing the service for the identified need.

HEALTHCARE VERIFICATION SECTION

Chronic Medical Diagnosis/Therapy/Dental/Counseling/other:

Symptom(s):

Expected frequency of visit: ____Weekly ____Bimonthly ____Monthly ____Other

Expected length of visit: ____ 1-2 hrs ____2-4 hrs ____over 4 hrs ____more than 1 day

Additional comments: _____

Healthcare Provider Authorized Signature/Title _____

Address: _____ Date: _____

_____ Phone: _____

PARENT AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby request and authorize the release of information on the above diagnosis and/or school attendance pertaining to my child above between Lewis County Schools' designated staff and _____(Healthcare Provider name).

Parent/Guardian Signature _____ Date: _____

Review/Revised:6/12/2023