



Peninsula Catholic High School

600 Harpersville Road, Newport News, Virginia 23601-1813

Telephone (757) 596-PCHS (7247), Fax (757) 591-9718

www.peninsulacatholic.com

Office of the Principal

Peninsula Catholic High School Chronic Illness Verification Form

Student: _____ DOB: _____ / _____ / _____ Grade: _____

Forward To (School): Fax Number: 757-591-9718

Dear Physician:

Your patient is a student enrolled in Peninsula Catholic High School. 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 it was received.

*Physician Signature: _____ Date: _____

***Note: An attached business card or letterhead is required.**

PHYSICIAN VERIFICATION

Chronic Illness/Medical Diagnosis:

Symptom(s):

Expected frequency _____ of episodes and length of absence per episode _____ day(s). (i.e., monthly, 4 times per school year).

Neurological System Respiratory System Gastrointestinal System Cardiovascular System

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> lethargy | <input type="checkbox"/> weakness/fatigue | <input type="checkbox"/> nausea/vomiting | <input type="checkbox"/> weakness/dizziness |
| <input type="checkbox"/> diarrhea | <input type="checkbox"/> dizziness/unsteadiness | <input type="checkbox"/> pallor/cyanosis | <input type="checkbox"/> severe headache |
| <input type="checkbox"/> palpitations | <input type="checkbox"/> constipation | <input type="checkbox"/> continual coughing | <input type="checkbox"/> numbness in extremities |
| <input type="checkbox"/> rapid pulse | <input type="checkbox"/> petit mal seizures | <input type="checkbox"/> congested airway | <input type="checkbox"/> abdominal pain |
| <input type="checkbox"/> arrhythmia | <input type="checkbox"/> grand mal seizures | <input type="checkbox"/> difficulty breathing | |
| <input type="checkbox"/> blurred vision | <input type="checkbox"/> fevers/infections | <input type="checkbox"/> pain | |

Genitourinary System Musculoskeletal System Ear, Nose and Throat Integumentary System

- | | | | |
|---------------------------------------|--|---|---|
| <input type="checkbox"/> skin lesions | <input type="checkbox"/> chronic infections | <input type="checkbox"/> bladder/kidney infection | <input type="checkbox"/> infections |
| <input type="checkbox"/> fever | <input type="checkbox"/> inflammation/swelling | <input type="checkbox"/> severe allergies | <input type="checkbox"/> pain |
| <input type="checkbox"/> fever | <input type="checkbox"/> severe asthma | <input type="checkbox"/> edema | <input type="checkbox"/> pneumonia/bronchitis |

Additional Comments:

To: _____ Physician's Name; _____ : Physician's Address

I hereby request and authorize the exchange of information on the above diagnosis pertaining to my child between designated staff of Peninsula Catholic High School and _____ (physician's name).

I understand with this verification, I must continue to provide written explanations to verify each absence.

Parent/Guardian Signature: _____ Date: _____