



SOUTH RIDGE HIGH SCHOOL

Attendance Verification Form for Students with Chronic Illness
1122 S. 67th Ave, Phoenix, AZ 85043 | (623) 247 - 0106 | FAX (623) 247 - 0527

STUDENT NAME	D.O.B.(MM-DD-YY)	GRADE
--------------	------------------	-------

The South Ridge High School Student Handbook states: "Arizona law requires that a student attend 90% of the time to receive credit. Attendance is mandatory. During a 45 day quarter, if a student accumulates more than five absences (excused and/or unexcused) during the quarter, the student may receive a letter grade of "F" in the class." **Chronic illness** or an emergency situation exceeding more than 3 absences will be dealt with on an individual basis through the administration.

NOTE: SECTION 1 and SECTION 2 to be completed by a Physician's Office

Dear Physician:¹

Your patient is a student enrolled at South Ridge High School. For our records, please list below the chronic illness diagnosed for this student. Also, please check or list the symptoms that would not warrant an office visit, but might require the child to stay home from school. This will allow the parent/guardian 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.

SECTION 1

Physician's Verification: X _____ Date _____
Physician's Signature

Chronic illness / medical diagnosis: _____

Symptom(s): _____

Expected frequency* _____ of episodes and length of absence per episode: _____ day(s).

*Examples: monthly, 4 times per school year, etc.

SECTION 2

- | | | | |
|--|---|---|--|
| 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"/> dizziness/unsteadiness | <input type="checkbox"/> pallor/cyanosis | <input type="checkbox"/> diarrhea | <input type="checkbox"/> pallor/cyanosis |
| <input type="checkbox"/> numbness in extremities | <input type="checkbox"/> continual coughing | <input type="checkbox"/> constipation | <input type="checkbox"/> palpitations |
| <input type="checkbox"/> epilepsy/seizures | <input type="checkbox"/> congested airway | <input type="checkbox"/> abdominal pain | <input type="checkbox"/> rapid pulse |
| <input type="checkbox"/> difficulty breathing | <input type="checkbox"/> pain | Ear, Nose & Throat | <input type="checkbox"/> pain |
| <input type="checkbox"/> arrhythmia | | <input type="checkbox"/> chronic infections | <input type="checkbox"/> fevers/infections |
| <input type="checkbox"/> severe headache | Genitourinary system | <input type="checkbox"/> severe allergies | Musculoskeletal system |
| <input type="checkbox"/> blurred vision | <input type="checkbox"/> bladder/kidney infection | <input type="checkbox"/> severe asthma | <input type="checkbox"/> pain |
| Integumentary system | <input type="checkbox"/> fever | <input type="checkbox"/> fever/infections | <input type="checkbox"/> inflammation/swelling |
| <input type="checkbox"/> skin lesions | | <input type="checkbox"/> pain | |
| <input type="checkbox"/> infections | Emotional / Psychological | <input type="checkbox"/> pneumonia/bronchitis | |
| <input type="checkbox"/> edema | | | |

Additional Comments: _____

SECTION 3 - To Be Completed by Parent/Guardian (Physician *can* write in contact information)

Parent/Guardian Authorization for Exchange of Information

My signature below authorizes the exchange of information, on the above diagnosis of my child, between the Administration at South Ridge High School and my child's physician whose name and phone number are as follows:

Physician's Name: _____ Physician's Office Number: _____

I understand that this information may be used for **attendance purposes only**. I further understand with this verification, I must submit a written explanation and call the school Attendance Office to verify each absence in order for the absences to be considered a result of the diagnosed chronic illness.

Parent /Guardian Signature _____ Date _____

¹ Adapted from Xavier College Preparatory Attendance Verification Form for students with Chronic Illness: <http://www.xcp.org/document.doc?id=40>