TEMPORARY COMPULSORY EDUCATION ATTENDANCE
HEALTH PROVIDER RECOMMENDATION

Student: _____ **DOB:** _____ **Grade:** _____

Forward (completed) to: _____ _____
School of attendance FAX number

Dear Physician,
Your patient is a student enrolled in _____ Unified School District. The family indicates that this student has a chronic illness that may require extensive absences and make regular school attendance difficult. If your records concur with this, please indicate below symptoms they may exhibit that would prevent school attendance.

Physician Verification

The above student is being treated by me for the following chronic illness(s):
_____

Based on medical concerns, the student should be excused from school attendance (dates) from_____ to return _____.

If the student's condition does not exempt school attendance, list any modifications to their school program

_____

Systems expected with the named chronic illness may include:

Neurological system
___ lethargy
___ dizziness/unsteadiness
___ numbness in extremities
___ petit mal seizures
___ grand mal seizures
___ severe headache
___ blurred vision

Respiratory system
____ weakness/fatigue
____ pallor/cyanosis
____ continual coughing
____ congested airway
____ airway breathing
____ pain

Gastrointestinal system
_____ nausea/vomiting
_____ diarrhea
_____ constipation
_____ abdominal pain

Genitourinary system
_____ bladder/kidney infection
_____ fever

Integumentary system
___ skin lesions
___ Infections
___ Edema

Cardiovascular system
____ weakness/dizziness
____ pallor/cyanosis
____ palpitations
____ rapid pulse
____ arrhythmia
____ pain
____ fevers/infections

Ear, Nose & Throat
_____ chronic infections
_____ severe allergies
_____ severe asthma
_____ fever
_____ pneumonia/bronchitis

Musculoskeletal system
___ Pain
___ inflammation/swelling

Additional Comments and/or Recommendations:

_____
_____
_____

*** PLEASE SIGN AND ATTACH YOUR BUSINESS CARD**

Physician's Signature_____
Date_____

(Complete Release of information on the back)

AUTHORIZATION FOR RELEASE OF INFORMATION

Completion of this document authorizes the disclosure and/or exchange of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information.

Regarding: _____
Full name | Date of Birth | Telephone number

Mailing Address: _____
City/Zip

I, the undersigned, authorize:

(Provider) Name _____ Phone

Address _____

City/Zip _____

to ☐ disclose ☐ receive (check all that apply)

Health information pertaining to any history, mental, physical condition and treatment my child has received:

to ☐ ☐ from (check all that apply)

Name _____ Phone

Address _____

City/Zip _____

For the purpose of improving academic success and providing most appropriate educational interventions.

Release or transfer of the referenced information to any person or entity not specified herein is prohibited. An additional written consent must be obtained for a proposed new use of the information or for its transfer to another person or entity.

If my child's health records include alcohol and/or drug abuse program information, I understand that the following statement applies to those records:

Federal law and regulations protect the confidentiality of alcohol and drug abuse records maintained by a program. Generally, disclosure of any information identifying a client as an alcohol or drug abuser is prohibited unless: 1) the client consents in writing, 2) the disclosure is allowed by a court order, 3) the disclosure is made to health care personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation, or 4) the client commits or threatens to commit a crime either at the program or against any person who works for the program. Violation of the federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations. Federal law and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities. (See 42 USC section 290dd-22 and 42 CFR Part 2).

I may cancel this authorization at any time by submitting the request in writing to the provider.
I may inspect or obtain a copy of the health information I have authorized for use or disclosure.
I have a right to have a copy of this authorization if requested.

This authorization expires one year from signing, unless otherwise noted.

_____
Signature of Parent/Legal Guardian of Student | Date of Signature