Rocklin Academy Charter School

5035 Meyers Street, Rocklin, California 95677
6532 Turnstone Way, Rocklin, California 95765
Telephone (916) 632-6580, Fax (916) 784-3034
www.rocklinacademy.com

Office of the Assistant Principal

Rocklin Academy
Chronic Illness Verification Form

Student: _____ DOB:_____/_____/_____ Grade:_____
Forward To (School): Fax Number: (916) 784-3034 or jantoon@rocklinacademy.org

Dear Physician:
Your patient is a student enrolled in Rocklin Academy Charter 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

__lethargy	__weakness/fatigue	__nausea/vomiting	__weakness/dizziness
__diarrhea	__dizziness/unsteadiness	__pallor/cyanosis	__severe headache
__palpitations	__constipation	__continual coughing	__numbness in extremities
__rapid pulse	__petit mal seizures	__congested airway	__abdominal pain
__arrhythmia	__grand mal seizures	__difficulty breathing	
__blurred vision	__fevers/infections	__ pain	

Genitourinary System, Musculoskeletal System, Ear, Nose and Throat, Integumentary System

__skin lesions	__chronic infections	__bladder/kidney infection	__infections
__fever	__inflammation/swelling	__severe allergies	__pain
__fever	__severe asthma	__edema	__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 Rocklin Academy Charter 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:** _____