Phoenix Union High School District
Student Health Services and Exceptional Student Services
MEDICAL CERTIFICATION FOR STUDENTS WITH CHRONIC HEALTH CONDITIONS FORM
FORMULARIO DE CERTIFICACIÓN MÉDICA PARA ESTUDIANTES CON CONDICIONES DE SALUD CRÓNICAS

School Year (Año Escolar): _____ Date of Birth (Fecha de Nacimiento): _____

Student Name (Alumno Nombre): _____ Grade (Grado): _____

High School of Record (Escuela de Registro): _____Student ID #: _____

I hereby authorize Phoenix Union High School District and my child's Healthcare Provider to exchange information provided on this medical evaluation form. I understand the medical evaluation performed by the physician or healthcare provider licensed in Arizona, determines the appropriate educational activities for my child and understand that is it my responsibility to notify the school of my child's absences. Each school year an updated Medical Certification form is required to verify the need for continuing instructional modifications and ADM adjustments, if applicable. However, the student recertification can occur at any time to reevaluate appropriate services needed. The parent/guardian is also responsible for notifying the school anytime there is a change in orders, medications, and/or change in condition.

Por la presente autorizo a Phoenix Union High School District y al proveedor de atención médica de mi hijo a intercambiar la información proporcionada en este formulario de evaluación médica Entiendo que la evaluación médica realizada por el médico o proveedor de atención médica con licencia en Arizona determina las actividades educativas apropiadas para mi hijo y entiendo que es mi responsabilidad notificar a la escuela las ausencias de mi hijo. Cada año escolar se requiere un formulario actualizado de Certificación Médica para verificar la necesidad de continuar las modificaciones de instrucción y los ajustes de ADM, si corresponde. Sin embargo, la recertificación de los estudiantes puede ocurrir en cualquier momento para reevaluar los servicios apropiados necesarios. El padre / tutor también es responsable de notificar a la escuela en cualquier momento que haya un cambio en las órdenes, medicamentos y / o cambio en la condición.

_____ _____ _____
Parent/Guardian Signature (Padres/Tutor Firma) Date Signed (Fecha) Telephone (Telephono)

MEDICAL STATEMENT – FOR HEALTHCARE PROVIDER USE ONLY (PLEASE WRITE LEGIBLY)

By state law A.R.S 15-346, students with chronic health conditions are those students who are not homebound, but who are unable to attend regular classes for intermittent periods of one or more consecutive days because of illness, disease, pregnancy complications, an accident or severe health problems of an infant child of a student as certified by a healthcare professional who is licensed pursuant to title 32, chapter 7, 8, 13, 14, 17 or 25 (licensed medical physician, osteopathic physician, podiatrist, naturopathic physician, chiropractor, physician's assistant) or a registered nurse practitioner who is licensed pursuant to title 32, chapter 15. Certification is not appropriate if the health condition is not sufficiently debilitating to prevent the student from attending school. Students identified by a licensed healthcare provider as having a chronic health condition that will affect regular school attendance shall have homework made available by their assigned teacher(s) in a timely to ensure that such students have the opportunity to successfully keep up with assignments and avoid losing credit because of their absence from school. Students with chronic health conditions shall be provided flexibility in physical education activity requirements so that they may participate in the regular physical education program to the extent that their health permits.

Student Medical Diagnosis: _____

_____

Is the student currently able to participate in physical activity? ☐ No ☐ Yes, with these accommodations:

_____

_____

Do you expect the student to miss more than 9 school days per semester? ☐ No ☐ Yes

Comments: _____

_____

Healthcare Provider Name: _____ Signature: _____ Date: _____

Telephone #: _____ Fax #: _____

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☐ Medical Alert- Chronic Health Condition Icon initiated by school personnel initials: _____ Date:_____

Board Policy Adopted 9/6/12 – JHD Exclusions and Exemptions from School Attendance/Chronic Health Conditions; A.R.S. 15-346
Resource Arizona School Board Association (ASBA) Policy Bridge; Form revised 2/10/19, 3/30/19