

# Certification of Chronic Medical Condition

Optional Form for California Licensed MD/DO/NP/PA

STUDENT NAME (Last, First, Middle)	DATE OF BIRTH
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**Certification of chronic symptoms**

I certify that this child has a physical or medical condition, specified below, with the following chronic symptoms that are unrelated to COVID-19, and recognize that a school health professional may call me for clarification or information about best management of this condition during the school day.

**Recurrent or chronic symptoms:**

Sign/Symptom(s)	Diagnosis and description of physical/medical condition(s) causing these symptoms Cite any abnormal labs, x-rays etc.	Year / Date Diagnosed
<input type="checkbox"/> Cough		
<input type="checkbox"/> Nasal congestion/rhinorrhea		
<input type="checkbox"/> Nausea/vomiting/diarrhea		
<input type="checkbox"/> Rash		
<input type="checkbox"/> Fatigue		
<input type="checkbox"/> Loss of taste/smell		
<input type="checkbox"/> Headache		
<input type="checkbox"/> Muscle/body aches		
<input type="checkbox"/> Poor feeding/appetite		
<input type="checkbox"/> OTHER: describe		

**Current treatment for above medical condition(s):** \_\_\_\_\_  
\_\_\_\_\_

**When this patient presents with symptoms of this chronic condition, would you like to assess and approve of school attendance first (to rule out COVID-19, for example) before the student resumes school attendance?**

Yes     No    Comments \_\_\_\_\_

**Additional comments:** \_\_\_\_\_

Licensed provider's **Printed** name, address, telephone & fax number:

Signature: \_\_\_\_\_

Please check:     MD     DO     NP     PA

License Number: \_\_\_\_\_

Date: \_\_\_\_\_