



Pre-School through Middle School
Supporting growth since 1979

Hermosa Montessori Charter School

Chronic Illness Need Certification Form

(Sections 2,3 and 4 to be completed by a Qualified Health Professional as defined under A.R.S. Title 32)

Section 1: Student Information

Student Name: _____
Date of Birth: _____
Grade: _____
Parent/Guardian Name: _____
Primary Phone: _____
Email: _____

Section 2: Health Professional Information

This section must be completed by a Qualified Health Professional licensed under A.R.S. Title 32, including:

Chapter 7: Podiatry

Chapter 8: Chiropractic

Chapter 13: Medicine, Surgery, Psychiatry (e.g., MDs)

Chapter 14: Naturopathic Medicine

Chapter 15: Nursing (including Licensed Nurse Practitioners)

Chapter 17: Osteopathic Physicians and Surgeons (e.g., DOs)

Chapter 20: Psychologist

Chapter 25: Physician Assistants

Health Professional Name: _____

Professional Credential (e.g., MD, DO, PA, NP, DC, DPM, ND): _____

Licensing Board (A.R.S. Title 32 Chapter): _____

License Number: _____

Practice/Clinic Name: _____

Phone: _____

Fax: _____

Address: _____

Section 3: Chronic Illness Certification

1. Diagnosis

Please indicate the diagnosed chronic illness or health condition that may cause intermittent school absences:

ICD-10 Code(s): _____

2. Duration of Condition

Temporary

Expected duration: _____

Chronic / Ongoing

Anticipated long-term management needed.

3. Expected Symptoms or Episodes That May Affect School Attendance

(Examples: fatigue, migraines, asthma attacks, seizure activity, gastrointestinal episodes, orthopedic limitations, chronic pain, anxiety, etc.)

4. Typical Frequency of Episodic Flare-Ups or Limitations

Based on reasonable medical judgment:

- Multiple times per week
- Weekly
- Monthly
- Unpredictable / Episodic
- Other: _____

5. How the Condition Impacts School Attendance or Participation

(Select all that apply and explain where needed.)

- Requires intermittent absences
- Requires modified participation in physical activity
- Requires access to medication during school hours
- Requires rest periods during the school day
- Requires medical monitoring or special care at school
- Other: _____

Describe impact:

6. Recommended Support or Accommodations (Non-Instructional Only)

Note: Recommendations should relate to health needs, not academic accommodations.

Section 4: Verification and Signature

I certify that the above information is accurate, that I am a Qualified Health Professional licensed under **A.R.S. Title 32**, and that this student has a chronic health condition that may reasonably result in intermittent school absences or health-related needs during the school day.

Health Professional Signature: _____

Date: _____

Section 5: Parent/Guardian Consent for Release of Information

(This section is to be completed by the parent/guardian.)

I authorize the health professional listed above to provide information to **Hermosa Montessori Charter School** for the purpose of verifying and supporting my child's chronic illness status and school health plan. I understand that this form is confidential and will be maintained in accordance with FERPA and HIPAA guidelines as applicable.

Parent/Guardian Signature: _____

Print Name: _____

Date: _____

Submission Instructions

Please return this completed form to:

Hermosa Montessori Charter School – Front Office or

submit via email: theresag@hermosaschool.org or fax: 520-749-6087