WEST VIRGINIA
VIRTUAL ACADEMY
POWERED BY K12

3508 Staunton Avenue, 3rd Floor • Charleston, WV 25304
wvva.k12.com

West Virginia Virtual Academy

CHRONIC MEDICAL CONDITION/DOCUMENTED DISABILITY ABSENCES REQUEST FORM

2024-2025

Please return completed packet to student's school.

Revised August 2024

DOCUMENTED CHRONIC MEDICAL CONDITION/DOCUMENTED DISABILITY

PARENT/GUARDIAN ROLE

The parent/guardian must work with WVVA to provide an uninterrupted, consistent education. Since only a portion of a student's studies are completed under the supervision of the teachers, the parent or guardian is responsible for supervising the independent studies. **This does not excuse the student from completing all class and school requirements.**

The parent's/guardian's responsibilities are:

1. Provide the school with a **completed** packet including:

    *Signed Parental Agreement Form

    *Signed Physician Agreement Form

    *Signed Authorization Consent/Release of Information Form

2. Contact the school and request assignments during the periods of time the student is not in school.

3. Return all completed work to the school in a timely manner and in accordance with the school's procedure.

4. Contact the school with any questions or concerns that develop.

5. Continue to have the licensed physician evaluate and update the student's health status during the time of this chronic condition.

6. **A written excuse for each absence must be sent upon return to school.** Please indicate your child has missed school due to the Chronic Medical Condition, which is on file, in order to code the absence correctly.

7. In order for your child to achieve academically, a student with excessive absences will need to meet with school staff and consult a physician to develop an educational plan and to determine if chronic medical conditions are appropriate.

8. The chronic medical condition request must be reviewed quarterly to determine continued eligibility based upon medical condition documentation.

9. The chronic medical condition packet must be renewed every school year.

CHRONIC MEDICAL CONDITION/DOCUMENTED DISABILTY PACKET

PARENTAL AGREEMENT FORM

Student's Name:_____

School:_____ **Grade:**_____

Parent's Name:_____

Phone Number:_____

Address:

_____

Physician's Name:_____

I have read the WVVA Chronic Medical Condition/Documented Disability Packet and agree to the guidelines established. I understand these guidelines must be followed for the student to assure a consistent educational process and a proper education for _____ Student's Name (Please print) _____ to occur.

AGREEMENT

I have read the WVVA Documented Chronic Medical Condition/Documented Disability Packet and agree to the guidelines established. I understand these guidelines must be followed for the student to receive a proper education. **I understand that this does not excuse the student from completing any and all class assignments.**

_____

Parent Signature Date

CHRONIC MEDICAL CONDITION/DOCUMENTED DISABILITY PACKET

RE:_____

Student Name (Please Print) **WVEIS #** **School**

WEST VIRGINIA VIRTUAL ACADEMY

3508 STAUNTON AVE 3RD FLOOR. Phone: 304-807-9370

CHARLESTON, WV 25304 Fax: 304-220-3104

DOCUMENTED CHRONIC MEDICAL CONDITION/DOCUMENTED DISABILITY

PHYSICIAN'S FORM

To the physician: The parent/guardian of the child listed has notified WVVA that the student has a chronic medical condition that may impact his/her regular daily school attendance. The West Virginia Board of Education (WVBE) Policy 4110 defines"Documented Chronic Medical Condition/ Documented Disability as:

Documented chronic medical conditions that may require multiple or regular absences. These conditions must be documented annually with a valid physician's note that explains the condition and anticipated impact on attendance. The necessity for the absences must be approved and reviewed quarterly by the SAT, IEP, or Section 504 team (see section 4.3.d.4).

Documented disabilities consisting of any mental or physical impairments that substantially limit one or more major life activities and are documented annually with a valid physician's note that explains the disability and the anticipated impact on attendance. The necessity for the absences must be approved and reviewed quarterly by the SAT, IEP, or Section 504 team (see section 4.3.d.4).

WVVA believes that a student's regular daily attendance is crucial to optimal learning as well as essential to the learning process; "classroom time lost" is irretrievable in terms of instructional interaction. WVVA is requesting that you verify this student's chronic medical condition/disability and its anticipated impact on school attendance.

Physician's Statement of Chronic Medical Condition/Disability:

_____

_____

_____

_____

How does this student's medical condition impact the child's school attendance?

_____

_____

_____

_____

How could the condition be monitored by the school nurse in order to lessen the need for absences from school?

Please provide a brief explanation for the student's need for additional parent excused absences:

How many times has the student been treated in your office or hospital for this chronic condition in the past 6 months?_____ past 12 months?_____

2024-2025
WVVA Required Student Attendance Days Per Month

August	10 Days	**September**	20 Days	**October**	23 Days
November	14 Days	**December**	15 Days	**January**	19 Days
February	15 Days	**March**	20 Days	**April**	18 Days
May	21 Days				
JUNE	5 Days				

☐ The student SHOULD NEED no more than _____ ADDITIONAL parent excused absences per month.

Expected expiration date:_____/_____/_____

OR

☐ The student DOES NOT NEED any additional parent excused absences per month.

Date of last appointment/office exam prior to today's date: _____/_____/_____

Physician's signature: _____

Date:_____/_____/_____

****Please include a copy of all medical records for this student (see the attached release of information form).**

I have a right to receive a copy of this Authorization. Signing the Authorization may be necessary in order for this student to obtain appropriate services in the School District.

APPROVAL:

Printed Name	Signature	Date
Relationship to Patient/Student	Area Code and Telephone Number	

WEST VIRGINIA VIRTUAL ACADEMY
FERPA/HIPAA CONSENT

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION BETWEEN HEALTH CARE PROVIDERS AND SCHOOL DISTRICTS

Completion of this document allows the disclosure and/or use of individual identified education records and health information, as set forth below, consistent with Federal laws (including HIPAA) concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization.

USE AND DISCLOSURE INFORMATION:

Patient/Student Name:_____
Last First MI Date of Birth

I, the undersigned, do hereby authorize (name of agency and/or health care providers):

(1) _____

(2)_____to provide health information from the above-named child's medical record to and from:

WEST VIRGINIA VIRTUAL ACADEMY
School District to Which Disclosure is Made

3508 STAUNTON AVE 3RD FLOOR CHARLESTON, WV 25304
Address/City and State/Zip

Nicole Colson/ Jean Vance
Contact Person at School District

304-807-9370
Area Code and Telephone Number

The disclosure of health information is required for the following purpose:

Description of Information to be Disclosed: I authorize the release and disclosure of any and all medical records, histories, reports, notes, diagnostic films or imaging, and all such other health information pertaining to_____, a minor, of whatever kind and character, and including but not limited to any psychiatric, psychological or mental health records, from_____ to the date this release is presented for such records, to the persons/entities identified herein.

DURATION:

This authorization shall become effective immediately and shall remain in effect for one year from the date of signature, unless sooner revoked by me in writing.

RESTRICTIONS:

Law prohibits the School District from making further or different disclosure of the health information contemplated by this Consent form unless another authorization form is obtained from me or unless such disclosure is specifically required or permitted by law.

YOUR RIGHTS:

I understand that I have the following rights with respect to this Authorization: I may revoke this Authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the school district/health care agencies/persons listed above. My refusal will be effective upon receipt but will not be effective to the extent that the Requestor or others have acted in reliance to this Authorization. I understand that any use or disclosure made prior to the effective revocation under this authorization will not be affected by a revocation.

RE-DISCLOSURE:

I understand that the School District will not improperly disclose this information, as prescribed by the Family Educational Rights and Privacy Act (FERPA) and that this information becomes part of the student's educational record upon being transmitted to a public school that receives federal funding. The information will be shared with individuals working at or with the School District for the purpose of providing safe, appropriate, and least restrictive educational settings, school health services, or other academic or extracurricular programs.