Office of the State Superintendent of Education

COVID-19 MEDICAL CONSENT & CERTIFICATION FOR DISTANCE LEARNING, SCHOOL YEAR 2021-22: HOUSEHOLD MEMBER CONDITION, DISTANCE LEARNING RECOMMENDED

This form should be used to request distance learning as a result of COVID-19 due to a health condition of a **household member** of a student. This form should NOT be used to document a requirement or recommendation of distance learning due to a health condition of a student, nor to document Home and Hospital Instruction requests for a student unrelated to COVID-19.

The parent/guardian (or adult student age 18 or older) and the affected household member must complete Part I. The parent/guardian (or adult student) must also complete Part IV.

The household member's healthcare provider must complete Part II.

The student's healthcare provider must complete Part III.

All fields in this form are required. Only those forms with complete responses in all fields will be considered.

PART I: TO BE COMPLETED BY THE PARENT/GUARDIAN OF THE STUDENT (OR THE STUDENT, IF AGE 18 YEARS OR OLDER) AND THE HOUSEHOLD MEMBER (OR THE HOUSEHOLD MEMBER'S PARENT/GUARDIAN, IF THE HOUSEHOLD MEMBER IS LESS THAN 18 YEARS OF AGE)

STUDENT INFORMATION

Student Name _____ DOB _____

Address _____ Phone _____

School of Enrollment _____

HOUSEHOLD MEMBER (*Individual living in the same household as the student listed above and whose medical condition places the individual at high risk for severe illness from COVID-19.*)

Household Member Name _____ DOB _____

Address _____ Phone _____

Student Name _____ DOB _____

CONSENT BY PARENT/GUARDIAN/ADULT STUDENT and HOUSEHOLD MEMBER:

I hereby authorize [insert name of healthcare provider(s)] and [insert name of school of enrollment] to discuss, release, or exchange information contained in or related to this form, and release information from all education and medical records concerning the request for registration in distance learning for the above-referenced student due to COVID-19. I understand that the information that is discussed, released or exchanged may be written and/or verbal, and will only be discussed, released or exchanged for the purpose of determining whether registration in distance learning is appropriate for the above-referenced student.

I understand that this medical certification form is subject to review and verification by my child's (or my, if I'm a student age 18 years or older) local education agency/school.

I understand that the period of validity for this medical certification form shall be for the 2021-22 school year.

I understand that this form and all supporting documentation will be retained by the school and I consent to their disclosure to the Office of the State Superintendent of Education (OSSE), external auditors, and other District agencies, including but not limited to the DC Office of the Inspector General and the DC Office of the Attorney General, upon request, for the purposes of auditing, verification, and/or investigation.

I understand that if I willfully make a false statement on this application or on material(s) submitted with this application, I can be prosecuted under D.C. Official Code § 22-2405, and could be subject to a fine of not more than $1,000, imprisonment of up to 180 days, or both.

Name of Parent/Guardian (or Student, if Age 18 Years or Older)_____ Phone _____

Signature of Parent/Guardian (or Student, if Age 18 Years or Older) _____ Date _____

Name of Household Member (or of Parent/Guardian of the Household Member, if the Household Member is less than 18 years of Age)

_____ Phone _____

Signature of Household Member (or of Parent/Guardian of the Household Member, if the Household Member is Less than 18 Years of Age)

_____ Date _____

PART II: MEDICAL CERTIFICATION:

To Be Completed by the Household Member's Licensed Physician, Nurse Practitioner or Physician Assistant

This form must be completed in its entirety. All information provided with this request is subject to verification.

Note: The Centers for Disease Control and Prevention (CDC) has defined a list of conditions that place an individual at higher risk for severe illness due to COVID-19. [1] *The CDC has not defined a list of health conditions for which distance learning is recommended for an individual due to a health condition of a member of their household. Such a decision must be made based on a clinician's best professional judgment.*

(household member name)

Patient Name _____ DOB _____

**The patient is the household member of the student listed below.*

Student Name _____ DOB _____

Student School of Enrollment _____

I HEREBY CERTIFY, based on providing direct patient care or reviewing medical documentation of such care, that the patient identified above (who has represented to me to be the household member of the student identified in Part I above) has the following health condition(s) that put(s) them at high risk of severe illness from COVID-19, consistent with guidance from the Centers for Disease Control and Prevention (CDC):

_____

☐ I HEREBY RECOMMEND that the student identified above participates in distance learning, because it is my professional opinion that the student's in-person attendance at school would endanger the patient due to their documented medical condition identified above.

PHYSICIAN, NURSE PRACTITIONER OR PHYSICIAN ASSISTANT SIGNATURE:

Name of licensed physician, nurse practitioner or physician assistant completing this form

_____

National Provider Identifier (NPI) Number _____

Practice Name _____

Address _____

Phone Number _____

Signature _____Date _____

Licensed physician, nurse practitioner or physician assistant practice stamp

1 www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html

PART III: CERTIFICATION OF VACCINE ELIGIBILITY:

To Be Completed by the Student's Licensed Physician, Nurse Practitioner or Physician Assistant

For any student for which distance learning is recommended due to a health condition of a household member, as certified by the licensed health care professional in Part II, this section is required and must be completed in its entirety. All information provided with this request is subject to verification.

Student Name _____ DOB _____

School of Enrollment _____

I HEREBY CERTIFY that the student identified above is ☐ eligible ☐ ineligible for a vaccine that is authorized for use in the United States to prevent COVID-19.

If ineligible for a vaccine that is authorized for use in the United States to prevent COVID-19:

Please describe why the student is ineligible for the COVID-19 vaccine:

☐ Age ☐ Medical condition _____ (please describe) ☐ Other _____ (please describe)

The student's ineligibility is ☐ permanent or ☐ temporary.

If the student is ineligible on a temporary basis for a vaccine that is authorized for use in the United States to prevent COVID-19, please indicate the date or circumstance upon which the student will become eligible for the COVID-19 vaccine.

_____

PHYSICIAN, NURSE PRACTITIONER OR PHYSICIAN ASSISTANT SIGNATURE

Name of licensed physician, nurse practitioner or physician assistant completing this form

_____

National Provider Identifier (NPI) Number _____

Practice Name _____

Address _____

Phone Number _____

Signature _____ Date _____

Licensed physician, nurse practitioner or physician assistant practice stamp

PART IV: DISTANCE LEARNING SUPPORTS:

To Be Completed By the Parent/Guardian (or Adult Student, if Age 18 Years or Older)

This Part IV is required and must be completed in its entirety. All information provided with this request is subject to verification

Local education agencies (LEAs) in the District of Columbia are providing distance learning to accommodate students with a medical need during the 2021-22 school year to protect the community from the spread of COVID-19.However, there is limited capacity for distance learning. Should more families request distance learning in the 2021-22 school year that there are available seats, LEAs and schools will need to determine which student(s) receive the available seat(s) in distance learning. To support LEAs and schools with making that determination and providing distance learning to students with a need and with a high likelihood of success in it, parents/guardians **must** respond to the following questions for review by their child's LEA or school. These responses will be used to demonstrate readiness and likelihood of success in distance learning. Please use the space provided except where indicated.

Student Name _____ DOB _____

School of Enrollment _____

1. **Describe the COVID-19 related health barriers that the student and/or family have experienced that make the student's in-person attendance a challenge in the 2021-22 school year. You may attach additional documentation to support your narrative response.**

2. **Describe how the parent or guardian will ensure the student's regular, timely participation in distance learning.**

3. **Describe the student's learning environment while attending school through distance learning and the steps the parent or guardian will take to provide age appropriate supervision and support so students can fully engage.**

4. **Does your child have access to the internet and a device for distance learning? If no, describe the supports needed from the school for securing access to the internet and a device for distance learning.**

Student Name _____ DOB _____

By signing this form, I acknowledge the following:

- I am requesting distance learning for my child or the child for whom I serve as guardian (referred to as "my child" throughout this).
- I understand that under D.C. law, education for my child is compulsory (required) for children between the ages of 5 and 18, it is not optional.
- I understand that if my child is absent from school without a valid excuse, it is unlawful.
- I understand that D.C. law limits the number of unexcused absences, whether from distance learning or in-person classes, a child may have before the school reports the child.
    - Students from ages 5 to 13: 10 full days of school - referrals to the Child and Family Services Agency (CFSA);
    - Students from ages 14 to 17: 15 full days – referrals to the Family Court Social Services Division of the District of Columbia Courts (FCSSD);
- My child's school may provide distance learning to my child if the standards described in this form are met, but it is not required to do so;
- I understand that any distance learning approved through review of this form will not extend beyond the 2021-22 school year;
- I understand that if my child is allowed to fulfill the education requirements through distance learning my child may return to in-person learning in the 2021-22 school year at the school's discretion;
- I understand that even if my child is permitted to participate in distance learning, regular attendance is required and collected daily. If a student misses school, the absence requires a valid excuse within 5 days of the absence in order for the absence to be considered excused.
- I understand that attending school remotely means reporting to all classes, and it may mean keeping the video on throughout classes if the classes are live and responding promptly when called upon;
- I understand that if my child does not have satisfactory attendance in school offered through distance learning at any point in the 2021-22 school year, the student's authorization for distance learning may be revoked and my child will be required to attend in person;
- I will support my child's learning in distance learning by providing them with a distraction-free space to participate in distance learning and maintain regular communication with my child's school as requested, or if my student or our household is having trouble complying with requirements for distance learning or attendance; and
- I will provide the appropriate level of supervision to ensure that the child is safe at home and on-task in distance learning.

Name of Parent/Guardian (or Student, if Age 18 Years or Older) Name _____ Phone _____

Signature of Parent/Guardian (or Student, if Age 18 Years or Older) Signature _____ Date _____

SCHOOL OFFICE USE ONLY | Medical Consent and Certification Form Received by School Official

Student Name _____ DOB _____