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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.  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.

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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 _____________________

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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 __________________________________ [ ] Other ________________________________

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
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2021-22 የትምህርት የታወ.WindowManager ትምህርት ድጋፍ መስጠት ይገባል። የትምህርት ነቀር ለመስጠት እንወስወስ እንደሚያረጋግጡ ግለጽ። በ2021-22 የትምህርት የጠየቅ የሚገኝ እና የተወጡ የጤና እንቅፋት እንደሚያረጋግጡ ግለጽ። በ2021-22 የትምህርት የጠየቅ የሚገኝ እና የተወጡ የጤና እንቅፋት እንደሚያረጋግጡ ግለጽ። በ2021-22 የትምህርት የጠየቅ የሚገኝ እና የተወጡ የጤና እንቅፋት እንደሚያረጋግጡ ግለጽ።
የወላጅ/አሳዳጊ (ወይም የተማሪ፣ ዕድሜው 18 ዓመት ወይም ከዚያ በላይ ከሆነ) ፊርማ __________________________ ቀን ________________