አሁኔታ፣ የዚህ ቅጽ የሚሰራበት ጊዜ ለ2021-22 ትምህርት ዘመን እንደሚሆን ተረድቻለሁ። ማወስወስ፣ ወይም በ2021-22 ትምህርት ዘመን እንደሚሆን ተረድቻለሁ። ይህ ቅጽ የሚሰራበት ጊዜ ለ2021-22 ትምህርት ዘመን እንደሚሆን ተረድቻለሁ። ይህ ቅጽ የሚሰራበት ጊዜ ለ2021-22 ትምህርት ዘመን እንደሚሆን ተረድቻለሁ። ይህ ቅጽ የሚሰራበት ጊዜ ለ2021-22 ትምህርት ዘመን እንደሚሆን ተረድቻለሁ። ይህ ቅጽ የሚሰራበት ጊዜ ለ2021-22 ትምህርት ዘመን እንደሚሆን ተረድቻለሁ።
PART II: MEDICAL CERTIFICATION:
TO BE COMPLETED BY LICENSED PHYSICIAN OR NURSE PRACTITIONER

This form must be completed in its entirety. All fields are required and 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 complications of COVID-19. ¹ The CDC has not defined a list of health conditions for which distance learning is required. Such a decision must be made based on a clinician’s best professional judgement.

Student Name ___________________________________________________ DOB ______________________

School of Enrollment __________________________________________________________________________________________

I HEREBY CERTIFY that the student identified has the following physical or mental health condition(s) which REQUIRES the student to participate in distance learning, due to COVID-19: ___________________________________________________________________

Describe how the student’s physical or mental health condition(s) above REQUIRES the student to participate in distance learning, due to COVID-19:

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PHYSICIAN OR NURSE PRACTITIONER SIGNATURE

Name of licensed physician or licensed nurse practitioner completing this form: ______________________________

National Provider Identifier (NPI) Number: ______________________________

Practice Name: ______________________________

Address: ______________________________

Phone Number: ______________________________

Signature: ______________________________

Date: ______________________________

Licensed physician or nurse practitioner office stamp:

SCHOOL OFFICE USE ONLY  | COVID-19 Medical Consent and Certification Form

School Official Name: ______________________________ Signature: ______________________________ Date: ______________________________