州教育厅长办公室（OSSE）

2021-22 学年 COVID-19/冠状病毒远程学习医疗同意书和证明有鉴于学生情况，必须进行远程教育

此表中的所有字段均为必填项。所有字段均完整答复的表格才将予以考虑。

**请注意，此表格只能用于记录必须进行远程学习的学生的健康状况。 如果因学生或家庭成员的健康状况，建议进行远程学习，或者是要记录与 COVID-19/冠状病毒无关的家庭和医院指导请求，请不要使用此表格进行记录。

第一部分： 由父母/监护人填写

学生信息

学生姓名 ______________________________ 出生日期 ______________

地址 ______________________________ 电话______________

入学学校 ______________________________

父母/监护人同意：

我特此授权______________________和______________________
讨论、发布或交流本表所包含的或与之相关的信息，或发布有关因 COVID-19/冠状病毒而为上述学生注册远程学习请求的所有相关教育和医疗记录信息。我了解所讨论、发布或交流的信息可能为书面和/或口头的形式，并且只为确定注册远程学习是否适合上述学生而进行讨论、发布或交流。

我了解本医疗证明表须经我孩子所在的当地教育机构/学校审查和核实。

我了解此医疗证明表格的有效期为 2021-22 学年。

我了解本表和所有支持文件将由学校保留，并且我同意应要求向 州教育厅长办公室（OSSE）、外部审计员和其他哥伦比亚特区机构披露，包括但不限于哥伦比亚特区监察长办公室和哥伦比亚特区总检察长办公室，以便进行审计、核查和/或调查。

我了解如果我蓄意在本申请或与本申请一起提交的材料中作出虚假陈述，根据《哥伦比亚特区官方法典》 第 22 章 2405 节，我有可能会被起诉，并可能被处以最高 1000 美元的罚款，最长 180 天的监禁，或两者并罚。

父母/监护人姓名 ______________________________ 电话 ______________

父母/监护人签名 ______________________________ 日期 ______________

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:

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: __________

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