Office of the State Superintendent of Education

COVID-19 MEDICAL CONSENT & CERTIFICATION FOR DISTANCE LEARNING, SCHOOL YEAR 2021-22: STUDENT CONDITION, DISTANCE LEARNING REQUIRED

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

*** Note, This form should only be used to document a student's health condition for which distance learning is required. This form should not be used to document a recommendation for distance learning due to the health condition of a student or a household member, nor to document Home and Hospital Instruction requests unrelated to coronavirus (COVID-19).*

PART I: TO BE COMPLETED BY THE PARENT/GUARDIAN

STUDENT INFORMATION

Student Name _____ DOB _____

Address _____ Phone _____

School of Enrollment _____

CONSENT BY PARENT/GUARDIAN:

I hereby authorize _____ and _____ to discuss, release, or exchange information contained in or related to this form, or release information from my child's education and medical records concerning my 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 local education agency/school.

I understand that the period of validity for this medical certification form shall be 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 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 submitted with this application, I can be prosecuted under DC Official Code § 22-2405, and could be subject to a fine of up to $1,000, imprisonment of up to 180 days, or both.

Parent/Guardian Name _____ Phone _____

Parent/Guardian Signature _____ Date _____

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