



## APPENDIX A: MEDICAL EMERGENCY TESTING EXEMPTION FORM

This form is to be used to verify, document, and approve the exemption of students during the DC CAS assessment due to a medical emergency. The following medical conditions must be met in order for the student to be excused from the state assessment.

Medical emergency exemptions from testing shall be granted on a case-by-case basis only. The definition of medical emergency is designed to exempt only those students whose conditions results in the student being too ill to be tested.

Medical emergencies are limited to student with life-threatening or severe illnesses or injuries. It does not provide a categorical exclusion for all home- or hospital-bound students; it applies solely to a student for whom a physician confirms is too ill at the time of testing to participate in the test.

A request for exemption from testing on these grounds must complete the attached form and must be accompanied by a signed statement from the student's treating physician. The statement must:

1. Describe the nature of the condition or extraordinary treatment; and
2. Confirm that the condition or extraordinary treatment has substantially prevented the student from accessing educational services since its inception or are too physically fragile to participate in the test.

Completed forms must be submitted to the LEA Assessment Coordinator before the first day of testing. LEA Assessment Coordinators in charter school LEAs must submit all completed forms to the DC Public Charter School Board (PCSB) before the first day of testing. Upon receiving the form, DCPS and PCSB must review the information each receives, issue a final determination, and return a copy of the package to the school. DCPS and PCSB are required to keep the information on file for at least three years. DCPS and PCSB must submit, at the conclusion of the test window, the total number of students exempted from testing and the name, student identification number, and school of each exempted student. The information must be submitted to:

DC Office of the State Superintendent of Education,  
Director of Assessments and Accountability  
ATTN: DC CAS Medical Exemptions  
810 First Street NE, 5th floor, Washington, DC 20002

OSSE may request documentation from DCPS or PCSB regarding exempted students.

Exempted students will not be included in a school's or LEA's Annual Measurable Objectives (AMO) calculations. Exemptions are valid only for the year in which they are requested; exemption status must be confirmed by DCPS or PCSB no later than the first day of testing.

**MEDICAL EMERGENCY TESTING EXEMPTION FORM**

**Section 1. Student information**

Student name: \_\_\_\_\_ Grade: \_\_\_\_\_  
Identification number: \_\_\_\_\_ School: \_\_\_\_\_

**Section 2. Explanation of absence**

To be completed by the student's parent or legal guardian.

Date of injury/illness: \_\_\_\_\_  
Description of injury/illness: \_\_\_\_\_

Parent signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Section 3. Physician diagnosis**

To be completed and signed by a licensed physician.

Physician name: \_\_\_\_\_  
Practice name: \_\_\_\_\_  
Address: \_\_\_\_\_  
State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone number: \_\_\_\_\_  
Primary diagnosis: \_\_\_\_\_

Physician's statement:

I hereby confirm that the absence of \_\_\_\_\_ (student name) is physician-advised due to a life-threatening illness or medical emergency. My signature certifies that I have examined the student named herein and I certify that the student is unable to participate in testing. The student should be excused for the following dates:

\_\_\_\_\_

Physician signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Section 4. Principal verification**

To be completed by the student's principal in order to verify that the form has been completed and also to verify the DC CAS absence dates. Once Sections 1-4 have been completed, the entire form should be faxed to (202) \_\_\_\_\_ Attention: \_\_\_\_\_. Keep the original on file at the school site.

Principal name: \_\_\_\_\_

Principal signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Section 5. Data & accountability confirmation**

To be completed by DCPS or PCSB.

Status:

Approved:  Denied:

Justification for denial: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Assessment director signature: \_\_\_\_\_ Date: \_\_\_\_\_



