



OFFICE OF THE STATE SUPERINTENDENT OF EDUCATION

## DC Statewide Assessments Medical Exemption Form

**Directions:** This form may be used to apply for a statewide test exemption on behalf of a student with an existing medical condition or medical emergency. One of the following circumstances must be met for an approved exemption from a statewide assessment:

1. The student has a **medical condition** or has become **seriously ill**  
*\*Medical exemption requests require both the statement and signature of the treating physician or psychiatrist to be completed on this form. This request must be submitted to OSSE **prior to the first day of testing at the student's school of record.***
2. The student experiences a **medical emergency** including but not limited to:
  - A life-threatening medical emergency
  - Severe injury
  - A mental health crisis

*\*Medical emergency exemption requests require both the statement and signature of the treating physician or psychiatrist to be completed on this form. Emergency exemption requests must be submitted to OSSE **no longer than 10 business days after the testing window closes.***

A request for exemption from testing on these grounds requires the submission of a completed medical exemption form in its entirety and 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 statewide assessment.

The school principal, principal's designee, or assessment coordinator must manage completion of appropriate sections of this form. Following completion, this form must be uploaded into the [OSSE Support Tool](#) by the timeframe specified above. OSSE will issue a final determination to the LEA. The LEA is required to keep the information on file for at least four years. School personnel are responsible for the mandatory filing of a copy of the completed DC Statewide Assessments Medical Exemption request form into the student's file.

Medical exemptions are valid during the school year for which they are approved. Please note that the Office of the State Superintendent of Education may require documentation from LEAs regarding student medical exemption requests. Students exempt from statewide assessments will not be included in LEA or school accountability calculations. To be considered a valid document for exemption, the form must include **a signed statement from the student's treating physician or psychiatrist**. Submissions without a valid signature may be considered a false certification of a test security form, a violation. Further, all fields on the form must be complete, correct and legible for students to be considered for a medical exemption.



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LEAs are to submit this completed and verified form to OSSE via the [OSSE Support Tool](#) document upload tool.

Please complete the table below:

Section 1. Student information	
LEA name or code:	School name or code:
Student name:	Student USI:
Student grade:	DC statewide assessment(s): <input type="checkbox"/> DC CAPE ELA/Literacy <input type="checkbox"/> MSAA ELA <input type="checkbox"/> ACCESS for ELLs <input type="checkbox"/> DC CAPE Mathematics <input type="checkbox"/> MSAA Mathematics <input type="checkbox"/> Alternate ACCESS <input type="checkbox"/> DC CAPE Science <input type="checkbox"/> Dynamic Learning Maps (DLM)
Section 2. Explanation of absence (to be completed and signed by the student's parent or legal guardian)	
Date of injury/illness:	Description of injury/illness:
Signature of parent or legal guardian:	Date of signature:
Section 3. Physician/Psychiatrist diagnosis (to be completed and signed by a licensed physician or psychiatrist)	
Physician/psychiatrist name:	Practice name:
Address (street, city, state, ZIP)	
Primary diagnosis:	Date(s) student is excused from assessment:
Physician's/Psychiatrist 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.	
Physician/Psychiatrist signature:	Date of signature:
Section 4. School and LEA verification	
Test integrity coordinator and test monitor must verify the completeness and accuracy of this form prior to submission to OSSE. The original copy of this completed form must be kept on file at the school site.	
Test monitor name:	
Test monitor signature:	Date:
Test coordinator name:	
Test coordinator signature:	Date:
OSSE staff signature:	Date: