POUGHKEEPSIE CITY SCHOOL DISTRICT

Virtual Instruction Request Form

Student name _______________________ School __________Grade _______Age_________

Student Address:______________ City: ________________State: ______Zip Code: ________

Parent or Guardian Name: ____

Phone number:____________________________ Email: ______________________________

PARENTAL CONSENT

I hereby authorize _____________________________________ (Healthcare Provider) and Poughkeepsie City School District (PCSD) 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 virtual instruction 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 virtual enrollment is appropriate for the above-referenced student.

Further, I understand that COVID-19 virtual instruction requests are subject to approval by PCSD based on the following criteria:

- Documentation of a health/medical need due to COVID-19 from a licensed medical provider [Medical Doctor (MD), Doctor of Osteopathic Medicine (DO), Physician Assistant (PA) or Advanced Practice Registered Nurse (APRN)]; AND,
- Documentation from a licensed medical provider indicating that the student REQUIRES virtual instruction because of a health/medical need due to COVID-19.

Parent Signature ____Date_________________

A statement of the patient's diagnosed medical condition(s) that increases their risk for serious illness, complications or death from COVID-19 from their healthcare provider is needed. It is important that the note not only lists a diagnosis, but that it also identifies the bodily system, at least one major life activity, and/or the organ function that the condition substantially impacts (or would impact without treatment). Please have your student's health care provider fill out the Medical Recommendation form.

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MEDICAL RECOMMENDATION FORM

TO BE COMPLETED BY A LICENSED MEDICAL PROVIDER [Medical Doctor (MD), Doctor of Osteopathic Medicine (DO), Physician Assistant (PA) or Advanced Practice Registered Nurse (APRN)]

The above-named parent/guardian, on behalf of their student, or adult student has indicated virtual school instruction is required for the student due to the student's health/medical need as a result of COVID-19. Please provide documentation on how virtual instruction supports the student's treatment plan by responding to each question below. This form must be completed in its entirety. All information provided with this request is subject to verification.

Onset of Care: _____________________________Date of Last Patient Visit: _______________

Current Diagnosis and reason for treatment as related to COVID-19: MUST Include Code (ICD-10 or DSM-5):

Describe the impact of the student's health/medical condition, due to COVID-19, that requires the student to participate in virtual instruction?

Dates of limitation duration: from ____________________________ until____________________

Name of Health Care Provider: ____

Practice Name:____

Practice Address:____

Phone Number:_______________Fax Number:_______________Email:__________________

Original Signature of Healthcare Provider and Date (Required): __________________________

Date: ________________

Comments____

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Please fill free to attached additional information on the letterhead of the Health Care Provider

Once completed this form should be submitted to student's building principal and school nurse

School Nurse Signature:____________________________________Date:_________________

School Administrator Signature: ______________________________Date:_________________

2021 – 2022 Academic Year