



SYRACUSE CITY SCHOOL DISTRICT

Health Services

Jaime Alicea, Superintendent of Schools

COVID-19 VIRTUAL SCHOOL PROGRAM APPLICATION

All medical records must be received prior to approval.

Student's Name: _____ DOB: _____

School: _____ Grade: _____ Student ID #: _____

Date of application: _____

Parent/Guardian Name: _____

Mailing Address: _____

Phone Numbers: Home: _____ Work: _____ Cell: _____

Email Address: _____

Emergency Contact and Phone Number: _____

Primary Doctor's Name _____

Address: _____

Phone Number: _____

TO BE FILLED OUT BY PARENT OR GUARDIAN:

- My child has **exceptional medical needs/compromised health** that would prevent him/her/them from safely returning to school in an in-person setting.
- My child **resides with an individual(s) with exceptional medical needs/compromised health** and would therefore benefit from virtual instruction to limit exposure to other individuals during the school day
****Medical documentation must be provided****

If you selected one of the boxes above, please confirm by checking the box below that **you will submit the COVID-19 Virtual School Medical Exemption Form by 8/27/2021** to complete your child's virtual learning option application process.

- If enrolled in the virtual learning option, my child would need access to a district-provided device to actively participate in virtual instruction.

I have obtained and attached a copy of my child's physical exam. Yes No Initials _____

APPLICATION WILL NOT BE REVIEWED IF YOU DO NOT PROVIDE A COPY OF THE PHYSICAL EXAM

Parent /Guardian Signature: _____

Print Name: _____

Date: _____

Student's Name: _____ DOB: _____

School: _____ Grade: _____ Student ID #: _____

TO BE COMPLETED BY PROVIDER: (PhD, and MSW will need to be co-signed by a physician)

Your patient has applied for the **COVID-19 Virtual School Program**. This program is designed for students with **exceptional medical considerations or living situations** requiring them to participate in virtual instruction. Please be certain your patient requires COVID-19 Virtual School Program instruction before you complete this form. An annual physical exam (within the past year) must be attached to this application.

Medical Diagnoses: _____

Psychological/Psychiatric Counseling: _____ required for
COVID-19 Virtual School Program due to Mental Health diagnosis

Surgical Procedure(s): _____

Medication(s): _____

Current status/disposition of patient: _____

Anticipated end date: _____

Last office visit: _____

How frequently do you see the patient? _____

Parents are required to provide medical updates every 90 days or at the end of the semester for COVID-19 virtual instruction

Why is your patient **medically** unable to attend in-person instruction in a regular classroom?

Can any reasonable accommodations be made to keep your patient in the classroom?

Yes, _____

No, _____

Thank you for your time. Please provide medical updates as requested. **PLEASE SEE INSTRUCTIONS ON PAGE 2 FOR WHEN STUDENT RETURNS TO SCHOOL. Please have parent sign a medical release of information for your office. Please forward a copy with this application.**

Date: _____

Provider's Signature: _____

Provider's Stamp - Required: _____

Address: _____

Phone Number: _____

Fax: _____

Student's Name: _____ DOB: _____

School: _____ Grade: _____ Student ID #: _____

TO BE COMPLETED BY MEDICAL DIRECTOR OR DESIGNEE:

- Recommended for Approval
 - COVID-19 Virtual School Program

- Not Approved
 - Missing physical exam
 - Missing other information _____
 - Missing doctor's notes
 - Missing medical release form
 - Other

Signature (Medical Director or designee): _____

COVID-19 VIRTUAL SCHOOL PROGRAM COMMITTEE REVIEW:

Committee members: _____

Comments: _____

Updates: _____

- Approved
 - COVID-19 Virtual School Program

NOT Approved

Reason: _____

Guiding Principles for Virtual School Program:

1. In-person learning is critical to supporting student academic success, emotional wellbeing and social development. The Syracuse City School District is excited and prepared to welcome back all students to in-person learning for the 2021-22 school year.
2. The district plans to utilize all Centers for Disease Control (CDC) and American Academy of Pediatrics (AAP) recommended safety measures in district buildings to ensure the health and safety of students, staff, and school visitors. The measures include mandatory mask-wearing (regardless of vaccination status), physical distancing, increased ventilation, daily sanitation, and frequent hand washing.
3. Students who are at increased risk of severe illness from COVID-19 (including **those who have significant medical needs or who reside with immunocompromised individuals**) will be given the option to receive core academic instruction virtually. Medical conditions* that increase the likelihood of severe illness from COVID-19 may qualify an individual for virtual learning. Medical conditions that do not increase the risk of severe COVID-19 disease do not qualify for virtual learning. In order to allow maximum participation of all students in in-person learning and prevent the spread of COVID-19, mitigation strategies are in place in the SCSD buildings. Strategies include health attestations (staying home when sick), masking, hand hygiene, social distancing, respiratory etiquette and air purification systems.
4. Families will need to apply for the COVID-19 Virtual School Program option **no later than 8/27/2021 in order for children to participate and no later than December 20, 2021 for the second semester**. All registration documents must include a medical form completed by a licensed medical professional that confirms that the student either has compromised health conditions themselves or resides with an individual(s) with compromised health conditions.
5. Virtual and in-person rosters will operate by semester. Changes or adaptations to in person and virtual school rosters will only happen at the start of each semester. Therefore, if you elect to have your child participate in the COVID-19 Virtual School Program at the beginning of the school year, they will not have the option to return to in-person instruction until January 2022.
6. Attendance policies and expectations will be consistent for all students in the district, regardless of how a student is receiving instruction. Students who elect to receive instruction virtually will need to attend the entirety of their classes for the duration of the school day in order to receive academic credit(s). Attendance of virtual classes will be monitored closely and follow up with families will occur as needed.
7. Synchronous: All classes are held synchronously (live instruction). Students are expected to be present on Teams for set periods of time during the regular school day.
8. Families are encouraged to engage in their child's virtual academic development and plan. Research indicates a clear need for parent involvement in a child's educational experience. Families that are involved with their child's educational experience have higher grades, show faster rates of literacy acquisition, attend school more regularly and, are more likely to graduate from high school and college.

*Examples of medical conditions that may qualify for Virtual School Program: Cancer, labile diabetes, kidney disease, organ transplant, immunodeficiency



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AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION TO SCHOOLS

Please sign this so that we may get health information from your child’s doctor.

Student Name: _____ DOB: _____ Date: _____

As the parent/guardian of the child named, the completion of this form authorizes your doctor, _____ to disclose your child’s confidential health-related information to his or her school.

(Name of Doctor)

The purpose for disclosing this information is to promote the accurate exchange of health information and for the coordination of care and treatment with the child’s school. This is important information for many reasons. For example, the school may need to know this information in order to give medications, monitor the child’s illness, and keep track of immunizations.

This authorization limits the disclosure of information to the following:

- Immunization information
- Physical exam reports
- Laboratory tests
- Medications and treatments

This authorization form does not allow the disclosure of confidential health information that is given special protection under the law. This includes HIV-related information, substance abuse information, psychiatric information and genetic information; the disclosure of this information requires a different specific form.

The information will be disclosed to the school in the school district indicated below until you tell us that the child is no longer an enrolled student at the school. You may revoke this authorization at any time by notifying the child’s healthcare provider in writing. Revoking this authorization means that we will no longer disclose the child’s information to their school. The child’s healthcare will not be affected if you do not authorize us to disclose their information to the school. In other words, we will not refuse your child treatment if you do not sign this authorization. The information we disclose to the school may be redisclosed to others by the school if the school is not required under law to protect the confidentiality of this information. Please keep a copy for your records.

Child’s Name (print)

Date of Birth

Parent/Guardian’s Name (print)

Relationship

Parent/Guardian’s Signature

School

Please return this form with your application.