

COVID-19 Health Eligibility Form

Please complete this form in its entirety and submit to
Denise Warnock, Assistant Superintendent, Emanuel County Schools
The application cannot be processed until all required documentation is submitted.

PART I: TO BE COMPLETED BY THE PARENT/GUARDIAN					
Student Name		School Name		Student ID #	Requested School Year
Student Address		City	State	Zip Code	Phone
Parent or Guardian Name			Email		
PARENTAL CONSENT: I hereby authorize _____ and Emanuel County Schools (ECS) to (healthcare provider) 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 enrollment 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 appropriate for the above-referenced student. Further, I understand that COVID-19 virtual enrollment requests are subject to approval by ECS based on the following criteria: - Documentation of a health/medical need due to COVID-19 from a licensed physician, nurse practitioner, psychiatrist, or licensed clinical psychologist; AND, - Documentation from a licensed physician, nurse practitioner, psychiatrist, or licensed clinical psychologist indicating that the student REQUIRES virtual instruction because of a health/medical need due to COVID-19. _____ Parent or Guardian Signature _____ Date					
PART II. TO BE COMPLETED BY A LICENSED PHYSICIAN, NURSE PRACTITIONER, PSYCHIATRIST OR LICENSED CLINICAL PSYCHOLOGIST					
The above-named parent/guardian, on behalf of their student, or adult student has indicated virtual school enrollment 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 enrollment supports the student's treatment plan by responding to each question below. <i>This form must be completed in its entirety.</i> 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: <u>MUST Include Code (ICD-10 or DSM-5)</u>					
Describe the impact of the student's health/medical condition, due to COVID-19, that requires the student to participate in virtual instruction?					
Printed Name of Health Care Provider			Practice Name		
Practice Address					
Phone Number		Fax Number		Email	
Original Signature of Healthcare Provider (Required)				Date	
Please provide any additional information or documentation on healthcare provider letterhead to attach with request.					