AKRON CENTRAL SCHOOL DISTRICT

Request for Exemption or Accomodation to
Distraction Free School Policy
Licensed Healthcare Provider Documentation Form

Student Name: _____ DOB: _____ Grade:____ Building: _____

Under which consideration are you seeking exemption for the student?

☐ Management of a health condition ☐ Caregiver of a family member
☐ Language translation consideration by _____ ☐ CSE/504 for other disability

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Student is diagnosed or experiencing the following _____ which requires access to a personal internet enabled device to accomplish the following activity/activities:_____. What type of personal device(s) does the student require access to? ☐ Cell Phone ☐ Watch ☐ Tablet ☐ _____

What specific application(s) or function(s) must the student have access to in order to accomplish the listed activity:

☐ Cellular calling, cell number(s): _____ ☐ Texting, cell number(s): _____
☐ Glucose Monitor app. _____ ☐ Heart Rate/ Other vital signs
☐ Photo/video ☐ Translation app. _____
☐ Other (please be specific) _____ ☐ Audible Alarm/Vibrating Alarm (circle)

Specify the locations the student will need to access the personal device during the academic day. *Check all that apply.*

☐ In Lunch Room ☐ Outdoors/Fieldtrips ☐ Classrooms ☐ In bathrooms/locker rooms ☐ Hallways

☐ On buses during the academic day (BOCES/trips)

Specify the situations/times students will need to access the personal device. *Check all that apply.*

☐ Continuously ☐ Upon Audible or Vibrating Alarm or Ring ☐ During a Medical Event/Emergency

☐ Specific Times: _____ ☐ Specific Situations: _____

☐ Other: _____

Device will be located: ☐ on person at all times ☐ in locker ☐ Other:_____

As the medical healthcare provider for the above named student, I am advising that it is necessary for the student to have a cell phone/internet enabled device during the school day. I understand that this is a request and the district will consider all appropriate accommodations.

☐ For the Academic Year ☐ from_____ to _____

HCP: _____ HCP (Signature): _____ Date: _____

Email: _____ Phone: _____

AKRON CENTRAL SCHOOL DISTRICT

Parent request for exemptions to Distraction Free School Policy & Consent to Communicate with HCP

Student Name: _____ DOB: _____ Grade:_____ Building: _____

A parent/guardian requesting permission for their child to have a cell phone/internet-enabled device accessible during the school day is required to have completed a **Licensed Medical Healthcare Provider Documentation Form** and authorize the District's Physician, or designee, to contact the child's provider. The district may choose to contact the provider at their discretion. Renewal requests must be resubmitted at the beginning of each school year or upon expiration of the initial request.

Requests for accommodations, or exemptions to the cell phone legislation and policy will be filtered to and considered by the appropriate department or committee. You will receive communication from the appropriate department or committee on your request within ten business days. Questions regarding the status of your request may be directed to your child's building principal.

It is important for all requesting parents to understand that an exemption does not authorize all activity on a student's personal cell phone, or internet enabled device. The District may hold students with exemptions accountable for activities that are outside the perimeters of the approval. This may include but is not limited to social media, texting, gaming, internet searches, and academic dishonesty.

Signature of Parent/Legal Guardian making request:_____Date:_____

As parent or legal guardian I authorize the healthcare provider indicated below (who completed the provider documentation form) to share protected health information with the District's Psychian, or designee of the Akron Central School District. This permission is for an exchange of information, discussion, or answering questions regarding my request for my child's school day access to a cell phone/internet enabled device. This permission is NOT an authorization to release medical records, or a consent to treatment. This permission authorizes the District's Physician or designee of the Akron Central School District to communicate with the authorized persons by phone (including voice messages), in person, or by other means acceptable to both parties.

Name of Healthcare Provider: _____ Phone Number: _____
Person giving consent: Name (print): _____ Date: _____
Signature: _____

PLEASE RETURN THIS FORM TO YOUR CHILD'S BUILDING PRINCIPAL

For District/School Use Only:

Date Received: _____

Reviewed By Medical Director: _____

Decision: ☐ Approved ☐ Denied

Notes:_____

_____

Administrator Signature: _____ Date Approved/Denied: _____