COMMUNITY CONSOLIDATED
SCHOOL DISTRICT 15

580 N 1st Bank Drive • Palatine IL 60067 | 847.963.3000 | www.ccsd15.net

District 15 Remote Learning Accommodation Form

Parents/guardians of students who want to apply for a medical exemption to participate in remote learning must complete this form. A student is eligible for remote learning only if District 15 receives this form with a statement from a licensed physician, physician assistant, or advanced practice registered nurse indicating that the student meets the following criteria: **1) their child is ineligible to be vaccinated, OR 2) is an immunocompromised individual**.

SECTION 1—To be Completed by Parent/Guardian Student

Name____ Grade ____________________

School ______________________________________ Student Birthdate__________________

I hereby request that my student receive remote instruction in lieu of in-person learning due to both of the reasons certified by the physician, physician assistant or advanced practice registered nurse indicated below. By signing this form, I acknowledge and accept the following.

- The District reserves the right to approve or deny any application for a Remote Educational Program, per Board policy
- Submission of an application does not guarantee approval for a Virtual Educational Program for your student, as noted above.
- As the school year progresses and ISBE and Illinois Department of Public Health (IDPH) updates their guidance and recommendations for schools, District 15 will notify parents and make adjustments as necessary.
- I authorize CCSD15 to exchange information with the health care provider completing the form to determine all potential learning options.

Parent/Guardian name (printed) ____

Parent/Guardian Signature ____

Date ____

SECTION 2—To be Completed by Licensed Health Care Provider

Patient's Name ____

(name of student or household member with increased risk)

Remote instruction is required for the student identified in Section 1 because:

[ ] The student is ineligible for a vaccine; **OR**
[ ] The student is an immunocompromised individual (please complete Section 2a).

Medical Certification: By signing this form, I certify that I am the health care provider of the above named individual and that based on current guidance issued by the Centers for Disease Control described below, the individual is at increased risk for severe illness if infected by the COVID-19 virus.

According to the CDC, individuals over the age of 65 are more likely to get severely ill from COVID-19. In addition, the CDC advises that adults of any age with the following conditions can be more likely to get severely ill from COVID-19: cancer, chronic kidney disease, chronic lung diseases (including COPD, moderate-to-severe asthma, interstitial lung disease, pulmonary fibrosis, cystic fibrosis and pulmonary hypertension), dementia or other neurological conditions, type 1 or 2 diabetes, Down syndrome, heart conditions (including heart failure, coronary artery disease, cardiomyopathies or hypertension), HIV infection, immunocompromised state (weakened immune system), liver disease, overweight (BMI >25 kg/m2, but <30 kg/m2), obesity (BMI ≥30 kg/m2 but <40 kg/m2), severe obesity (BMI ≥ 40 kg/m2), pregnancy, sickle cell disease or thalassemia, smoking (current or former), solid organ or blood stem cell transplant (including bone marrow transplants), stroke or cerebrovascular disease, or substance abuse disorders.

SECTION 2a *(to be completed by health care provider for students with special health care needs)*

By signing below, I certify that the student named in Section 1 above has the following special health care needs, which prevent the student's safe school attendance under current conditions and require the continuation of the remote learning program.

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Print Name of Physician, Physician Assistant or Advanced Practice Registered Nurse

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Signature of Physician, Physician Assistant or Advanced Practice Registered Nurse

______________________ ______________________
Health Care Provider Address *Health Care Provider Telephone*

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Date