COVID-19 Health Eligibility Form

Please complete this form in its entirety and email to virtualenrollmentNEW@cps.edu. Please notify your school for any change in address or contact information. An updated and accurate email and home mailing address is required for notification. The application cannot be processed until all required documentation is submitted.

PART 1: TO BE COMPLETED BY THE PARENT/GUARDIAN

Student Name | School Name | Student ID #

Student Address | City | State | Zip Code | Phone

Parent or Guardian Name | Email

I would like to be notified of the application results by: ☐ Email ☐ Letter to Student Address

PARENTAL CONSENT: I hereby authorize (healthcare provider) and Chicago Public Schools (CPS) 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 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 is appropriate for the above-referenced student.

Further, I understand that COVID-19 virtual enrollment requests are subject to approval by CPS 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. A list of medically fragile conditions can be found at cps.edu/VirtualAcademyRequirements

Parent or Guardian Signature | Date

PART II: 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 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. 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?

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.