Glen Ellyn School District 41

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793 North Main Street, Glen Ellyn, IL 60137

PHYSICIAN CERTIFICATION FOR REMOTE INSTRUCTION

Pursuant to guidance issued by the Illinois State Board of Education ("ISBE") and the Illinois Department of Public Health ("IDPH") ("Joint Guidance"), school districts should return to in-person instruction as soon as practicable in every Illinois community. The Joint Guidance and the ISBE FAQ direct school districts to continue to offer the option of remote instruction to students (1) who are at increased risk of severe illness, (2) who have special health care needs, or (3) who live with people at increased risk. Revised Public Health Guidance For Schools, Part 4 – Transition Joint Guidance, March 9, 2021.

For students who are unable to return to in-person instruction due to one or more of the exemptions above, please ask your child's/family's physician to complete the form below and return it to Assistant Superintendent Dr. Katie McCluskey.

1. **STUDENT INFORMATION** ***(completed by parent/guardian)***

Student's Name ______________________________ Date of Birth __________________________

Student School ____ Grade___________________

Parent or Guardian Name ____

Home Phone Number ___________________ Cell Number ________________________________

Home Address____

Work Number_________________________ E-mail _____________________________________

Form Completed by:____

2. **PHYSICIAN INFORMATION** ***(completed by physician)***

Physician's Name (Print)_____________________________ License Number ________________

Physician's Specialty (area of practice) ____

Phone _____________ Fax _______________ Physician's E-mail ___________________________

Hospital Affiliation(s) ____

Physician's Signature ______________________________________ Date Signed_______________

3. **QUALIFYING STUDENT EXEMPTION FOR REMOTE INSTRUCTION** ***(completed by physician; please attach physician's orders)***

Date of Most Recent Medical Examination: ____

Please check if any of the following apply:

- □ Student has a medical condition that places him/her at increased risk of serious illness.
- □ Student has special health care needs.
- □ Student lives with person/people at increased risk of serious illness.

Describe medical condition(s) that precludes the student's ability to return to in-person instruction (e.g., condition leading to increased risk of serious illness or special health care need): ____________________
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____
____

Anticipated duration of the student's need for remote instruction: __________________________
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____

4. **OTHER INFORMATION, IF APPLICABLE** ***(including accommodations that could facilitate the student's return to in-person instruction)***

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5. **RELEASE OF INFORMATION**

I hereby grant my consent to ____ **(school name)** to communicate and exchange any and all student record and medical information with the physician listed above in Section 2 of this form. The purpose for this disclosure is educational planning. If I do not grant this consent, the District will not exchange information with the physician, but I will not suffer any other consequences. This consent is valid for one calendar year from the date set forth below, and may be revoked at any time in writing.

Parent/Guardian Name: ____

Parent/Guardian Signature: ____

Date: ___________________