Ithaca CITY SCHOOL DISTRICT

COVID-19 Health Eligibility Form
Provider Attestation

INSTRUCTIONS

Please complete this form in its entirety and email it to healthalerts@icsd.k12.ny.us or fax it to (607) 645-4203. Be sure to notify your school of any change in address or contact information. An updated and accurate email or home mailing address is required for notification. All required documentation should be submitted by **August 26, 2021**.

PART I: TO BE COMPLETED BY THE PARENT/GUARDIAN

Student Name: _____ Student Date of Birth (mm/dd/yy): _____

School Name: _____ Grade: _____

Parent or Guardian Name: _____

Mailing Address: _____
Street *City* *State* *Zip Code*

Phone Number: _____

Email: _____

I would like to be notified by: ☐ Email ☐ Letter

PARENT/GUARDIAN CONSENT

I hereby authorize _____ and the Ithaca City School District (ICSD) to:
(healthcare provider)

- discuss, release, or exchange information contained in or related to this form; or
- release information from my child's education and health records concerning my request for non-in-person 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 non-in-person instruction is appropriate for the above-referenced student.

Further, I understand requests are subject to review by an ICSD-appointed committee of healthcare professionals.

_____ _____
Parent or Guardian Signature Date

PART II: TO BE COMPLETED BY A NYS LICENSED HEALTHCARE PROVIDER

The above-named parent/guardian, on behalf of their student, has indicated non-in-person instruction is required for the student due to the student's health/medical need as a result of COVID-19. Please provide documentation on how non-in-person instruction supports the student's plan of care 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: _____

This student is not eligible for the vaccine, has a CDC-recognized diagnosis that puts them at medical risk due to COVID-19, and cannot return to in-person instruction at this time. Check all diagnoses that apply:

- ☐ Medical complexity, with genetic, neurologic, metabolic conditions
- ☐ Congenital heart disease
- ☐ Obesity
- ☐ Diabetes
- ☐ Asthma or chronic lung disease
- ☐ Sickle cell disease
- ☐ Immunosuppression

This student will become eligible for the vaccine on: _____
Date (mm/dd/yy)

This child should not get the vaccine due to the following COVID-19 vaccine contraindication(s). Guidance on contraindications can be obtained from the Centers for Disease Control and Prevention: https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html#Contraindications

- ☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a component of the COVID-19 vaccine
- ☐ Immediate allergic reaction of any severity to a previous dose or known (diagnosed) allergy to a component of the vaccine

☐ Student is able to participate in extracurricular activities (e.g., athletics, performing arts, clubs, etc.)

A New York State licensed healthcare provider must complete this form and provide their information below:

Name (print): _____ NYS License #: _____

Practice Name & Address: _____

_____ Phone Number: _____

Signature: _____ Date: _____

Please provide any additional information or documentation on letterhead to attach with request.