# COVID-19 健康资格表

请完整地填写本表格，并提交到 virtualenrollment@fcps.edu.
在提交所有要求的文件之前，申请不能得到处理。

**第一部分：由家长/监护人填写**

| 学生姓名 | 学校名称 | 学号 | 要求注册的学年 |
|---|---|---|---|
| | | | |

| 学生住址 | 城市 | 州 | 邮编 | 电话 |
|---|---|---|---|---|
| | | | | |

| 家长或监护人姓名 | 电邮 |
|---|---|
| | |

**家长同意** 我在此授权 _____ 和费郡公立学校 (FCPS) 讨论，公布，或
(医疗保健提供者)
交换本表格中包含的或与之相关的信息，或发布我孩子的教育和医疗记录中有关我**因新冠疫情**而要求上述学生参加虚拟教学的信息。我明白，所讨论、发布或交流的信息可能是书面和/或口头的，而且只为确定虚拟教学是否适合上述学生的目的而讨论、发布或交流的。

此外，我明白新冠疫情虚拟入学申请须经费郡公立学校根据以下标准批准：

- 由持照医生、执业护士、精神病医生或持证临床心理学家提供的因新冠疫情引起的健康/医疗需要的文件；以及，
- 持照医生、执业护士、精神病医生或持证临床心理学家提供的文件，表明学生**因新冠疫情**的健康/医疗需要而**需要参加**虚拟教学。

| 家长/监护人签字： | 日期： |
|---|---|
| | |

**第二部分：由持照医生、执业护士、精神病学家或持证临床心理学家填写**

上述家长/监护人代表其学生或成年学生表示，**由于新冠疫情所造成的医疗、情感或社交影响**，学生需要参加虚拟教学。请提供文件，说明虚拟教学如何支持学生的治疗计划，并回答以下每个问题。***必须完整地填写本表格。***与本表格相关的一切信息都要经过核查。

| 开始提供医疗照料的日期 | 病人最后一次看病的日期 |
|---|---|
| | |

与新冠病情相关的诊断或治疗原因。必须包括代号 (ICD-10 或 DSM-5)

请描述由于新冠疫情引起的健康/医疗需要，学生需要参加虚拟教学。

| 请用大写字母写出医疗保健提供者的姓名 | 医疗机构名称 |
|---|---|
| | |

医疗机构地址

| 电话号码 | 传真号码 | 电邮 |
|---|---|---|
| | | |

| 医疗保健提供者原始签字（必须提供） | 日期 |
|---|---|
| | |

请在医疗机构信笺上提供任何与本申请相关的其他信息或文件。

Fairfax County PUBLIC SCHOOLS
ENGAGE • INSPIRE • THRIVE

# COVID-19 Health Eligibility Form

Please complete this form in its entirety and submit to virtualenrollment@fcps.edu.
The application cannot be processed until all required documentation is submitted.

## PART I: TO BE COMPLETED BY THE PARENT/GUARDIAN

| Student Name | School Name | Student ID # | Requested School Year |
|---|---|---|---|
| | | | |

| Student Address | City | State | Zip Code | Phone |
|---|---|---|---|---|
| | | | | |

| Parent or Guardian Name | Email |
|---|---|
| | |

**PARENTAL CONSENT:** I hereby authorize _____ (healthcare provider) and Fairfax County Public Schools (FCPS) 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 FCPS based on the following criteria:

- Documentation of a health/medical need **due to COVID-19** from a licensed physician, nurse practitioner, psychiatrist, or licensed clinical psychologist; **AND**,
- Documentation from a licensed physician, nurse practitioner, psychiatrist, or licensed clinical psychologist indicating that the student **REQUIRES** virtual instruction because of a health/medical need **due to COVID-19.**

_____ _____
Parent or Guardian Signature Date

## PART II. TO BE COMPLETED BY A LICENSED PHYSICIAN, NURSE PRACTITIONER, PSYCHIATRIST OR LICENSED CLINICAL PSYCHOLOGIST

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.