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 _____ and Fairfax County Public Schools (FCPS) to
(healthcare provider)
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.