Coldspring-Oakhurst
CONSOLIDATED I.S.D.

Medical Certification for COVID-19 High Risk Exemption

Student name:	Campus:

Should a student be required to return to in-person instruction, but the student or an individual in his/her household has a high-risk medical condition as defined by the Centers for Disease Control, this medical certification form will need to be submitted in order for the student to be considered for remote learning.

Completed forms should be submitted to the COCISD administration office in-person, or via email to info@cocisd.org, to claim the high-risk exemption for COVID-19. Forms must be signed by a licensed health care provider and are subject to verification. Parents/Guardians will be notified when the form has been approved.

Individual at Higher Risk: Individuals at higher risk for severe illness from COVID-19 are those individuals with certain underlying heath conditions as designated by the CDC, which provides as follows:
Those individuals who are at higher risk of severe illness, as designated by the Centers for Disease Control (CDC), are those with conditions such as asthma, chronic lung disease, compromised immune systems (including from smoking, cancer treatment, bone marrow or organ transplantation, immune deficiencies, poorly controlled HIV or AIDS, or use of corticosteroids or other immune weakening medications), diabetes, serious heart disease (including heart failure, coronary artery disease, congenital heart disease, cardiomyopathies, and hypertension), chronic kidney disease undergoing dialysis, liver disease, or severe obesity.

To be completed by the Health Care Provider

Health Care Provider's Name: _____

Health Care Provider's Address: _____

Type of practice / Medical specialty: _____

Telephone:_____ **Fax:** _____

1. Does the named student or individual in his/her household have an underlying medical condition deemed to be high risk for severe illness from COVID-19 as determined by the CDC and listed above? ☐ Yes ☐ No
2. If yes, please provide the medical diagnosis of the underlying condition (as identified by the CDC) for this student.

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Signature of Health Care Provider **Date**

Received by: _____ Date: _____