



Winchester Public Schools
Medical Certification Form for Virtual Learning

Part 1: To be completed by Parent/Guardian

Student Name: Date of Birth: Grade:
Address: School Student Attends:
Parent/Guardian Name: Email:

Authorization of release of information: I authorize the medical provider noted below and Winchester Public Schools to discuss, release, or exchange information contained in or related to this form, or release information concerning the request for my student's enrollment in virtual learning.

Medical Provider's Name:
Address: Phone Number:
Parent/Guardian Signature:

Completion of this form is not a guarantee of placement in the Distance Learning Program.

Part 2: To be completed by the Medical Provider of the student.

Your professional input is necessary to determine, based on the student's health, if this student would be best served by a full year of virtual learning. If the student's medical condition prohibits them from participating in a full-time, virtual learning (5-7 hours daily), you should not recommend virtual learning.

Student Name: Date of Birth:

I HEREBY CERTIFY that the student identified has the following physical or mental health condition which REQUIRES to participate in virtual learning due to COVID-19: Include Code (ICD-10 or DSM 5).

Describe how the physical or mental health condition(s) above REQUIRES the student to participate in virtual learning due to COVID-19.

Name of licensed physician/NP/PA completing this form:

National Provider Identifier (NPI) Number:

Practice Name: Phone Number:

Signature: Date:

Please return this form to Judy McKiernan @ mckiernan.judy@wps.k12.va.us or FAX: 540-678-3583. Thank you.



Escuelas Públicas de Winchester  
Formulario de Certificación Médica para el Aprendizaje Virtual

Parte 1: Para ser completado por el padre / tutor

Nombre del estudiante: \_\_\_\_\_ Fecha de nacimiento: \_\_\_\_\_ Grado: \_\_\_\_\_  
Dirección: \_\_\_\_\_ Escuela a la que asiste: \_\_\_\_\_  
Nombre del padre / tutor: \_\_\_\_\_ Correo electrónico: \_\_\_\_\_

**Autorización para compartir información:** Autorizo al proveedor médico a continuación y a las Escuelas Públicas de Winchester a discutir, comunicar o intercambiar información contenida en este formulario o relacionada con el mismo, o comunicar información sobre la solicitud de inscripción de mi estudiante en el aprendizaje virtual. La información comunicada o intercambiada puede ser escrita y / o verbal, y solo se discutirá, comunicará o intercambiará con el propósito de determinar si el Programa de Aprendizaje Virtual es apropiado para el estudiante mencionado previamente.

Nombre del médico: \_\_\_\_\_  
Dirección: \_\_\_\_\_ Número de teléfono: \_\_\_\_\_  
Firma del padre / tutor: \_\_\_\_\_

El completar este formulario no es garantía de ser incluido en el Programa de Educación a Distancia.

Part 2: To be completed by the Medical Provider of the student. (Para ser completado por el médico)

Your professional input is necessary to determine, based on the student's health, if this student would be best served by a full year of virtual learning. If the student's medical condition prohibits them from participating in a full-time, virtual learning (5-7 hours daily), you should not recommend virtual learning. The parent/guardian should contact the school to discuss alternative learning options, and you should not recommend virtual learning.

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I HEREBY CERTIFY that the student identified has the following physical or mental health condition which REQUIRES to participate in virtual learning due to COVID-19: Include Code (ICD-10 or DSM 5).

Describe how the physical or mental health condition(s) above REQUIRES the student to participate in virtual learning due to COVID-19.

Name of licensed physician/NP/PA completing this form:

National Provider Identifier (NPI) Number: \_\_\_\_\_

Practice Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please return this form to Judy McKiernan @ [mckiernan.judy@wps.k12.va.us](mailto:mckiernan.judy@wps.k12.va.us) or FAX: 540-678-3583.  
Thank you.