STUDENT COVID-19 CHRONIC SYMPTOM EXEMPTION

TO BE COMPLETED BY HEALTHCARE PROVIDER, PARENT/ GUARDIAN, & NURSE

Optional Student Photo

EFFECTIVE DATE:		End Date:
STUDENT'S NAME:	Grade:	Date of Birth:
HEALTHCARE PROVIDER INFORMATION Name/ Clinic:		
SCHOOL:	Nurse Phone #:	Fax #:

This exemption is for students that have symptoms associated with a non-COVID-19 chronic medical condition. Students will not be excluded from in-person school for the identified symptom(s) as long as they have not worsened and the student has no additional symptoms that are NEW. Any new or worsened symptoms associated with COVID-19 will be regarded as possible COVID-19. This exemption is in addition to any current care plan(s) and current school plans for COVID-19 Policies and Procedures. **This form must be updated annually.**

Diagnosis/Condition(s) & Pertinent Health History:_____

_____

Symptom Exemptions:

Symptom:	Notes/ Additional Information:

MEDICAL PROVIDER WITH PRESCRIPTIVE AUTHORITY IN ALASKA (PRINTED)	TELEPHONE NUMBER
MEDICAL PROVIDER SIGNATURE AND CREDENTIALS	DATE

PARENT / GUARDIAN AGREEMENT & AUTHORIZATION		
I hereby give permission for my child to have this specialized symptom exemption plan in place as authorized by my child's health care provider. Permission is also given for the school nurse to contact the health care provider regarding this symptom exemption. I agree to save, defend and hold harmless the Fairbanks North Star Borough School District, its employees, elected or appointed officials, from any liability or damages as a result of the above listed symptom exemption. I agree to notify the school nurse immediately of any changes in care, procedures or discontinuance of the above listed symptom exemption.		
PARENT / GUARDIAN NAME (PRINTED)	RELATIONSHIP TO CHILD	TELEPHONE NUMBER
PARENT / GUARDIAN (SIGNATURE)		DATE

NURSE PLAN REVIEW	
☐ **Reviewed by School Nurse.**	
NURSE NAME (PRINTED)	
NURSE SIGNATURE	DATE