



# Ingram Independent School District

*Inspiring Student Success from the Inside Out*

## Appeal for Continued Remote Instruction

**Directions:** Complete this form, the Medical Certification for COVID-19 High Risk Exemption (if applicable), and attach any additional documentation to support the appeal based on COVID-19 High Risk Medical Condition. Submit all documents to your child's campus by Friday, December 11, 2020. The appeal will be reviewed by a committee and you will receive the decision by December 18, 2020.

Student's Name \_\_\_\_\_ Grade \_\_\_\_\_

Guardian's Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Address \_\_\_\_\_

List other children who live at this same address who are students at Ingram ISD.

Name	Campus

List additional names on the back of the form if needed.

Person in the household that has a Covid-19 High Risk Medical Condition:

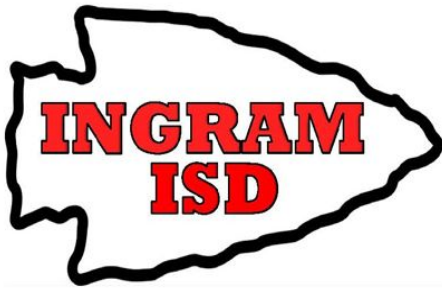
\_\_\_\_\_

If the student has a high risk health condition, have your Health Care Provider complete the **Medical Certification for COVID-19 High Risk Exemption**.

If another member of the household has a high risk health condition, provide documentation of the condition. For example: Information similar to that on the Medical Certification for COVID-19 High Risk Exemption completed by a Health Care Provider. Provide any additional information for the committee to consider:

The Appeals Committee, made up of Ingram ISD staff members, will meet during the week of December 14th. Administrators from your child’s campus are not voting members of this committee. If the committee requires additional information, you will be contacted. The committee will review and may consider your child’s academic achievement and attendance records when making a determination. The committee decision is final and parents will be notified on or before Friday, December 18.

If you have any questions, please contact Karen Bordovsky, Chief Compliance Officer, at [kbordovsky@ingramisd.net](mailto:kbordovsky@ingramisd.net)



# Ingram Independent School District

*Inspirar el éxito de los estudiantes desde adentro hacia afuera*

## Apelación para instrucción remota continua

**Instrucciones:** Complete este formulario, la Certificación médica para la exención de alto riesgo de COVID-19 (si corresponde) y adjunte cualquier documentación adicional para respaldar la apelación basada en la condición médica de alto riesgo de COVID-19. Envíe todos los documentos al campus de su hijo antes del Viernes 11 de Diciembre de 2020. La apelación será revisada por un comité y usted recibirá la decisión antes del 18 de Diciembre de 2020.

El nombre del estudiante \_\_\_\_\_ Grado \_\_\_\_\_

Nombre del tutor \_\_\_\_\_ Número de teléfono \_\_\_\_\_

Dirección \_\_\_\_\_

Enumere otros niños que viven aquí y que son estudiantes de Ingram ISD.

Nombre	Instalaciones

Mencione nombres adicionales en el reverso del formulario si es necesario.

Persona en el hogar que tiene una condición médica de alto riesgo Covid-19:

\_\_\_\_\_

Si el estudiante tiene una condición de salud de alto riesgo, pídale a su proveedor de atención médica que complete la Certificación médica para la exención de alto riesgo COVID-19.

Si otro miembro del hogar tiene una condición de salud de alto riesgo, proporcione documentación de la condición. Por ejemplo: Información similar a la de la Certificación médica para la exención de alto riesgo de COVID-19 completada por un proveedor de atención médica.

Proporcione cualquier información adicional para que el comité la considere:

El Comité de Apelaciones, compuesto por miembros del personal de Ingram ISD, se reunirá durante la semana del 14 de Diciembre. Los administradores del campus de su hijo no son miembros votantes de este comité. Si el comité requiere información adicional, lo contactaremos. El comité revisará y podrá considerar el rendimiento académico y los registros de asistencia de su hijo al tomar una determinación. La decisión del comité es final y los padres serán notificados el viernes 18 de diciembre o antes.

Si tiene alguna pregunta, comuníquese con Karen Bordovsky, Directora de Cumplimiento, al [kbordovsky@ingramisd.net](mailto:kbordovsky@ingramisd.net)



### Medical Certification for COVID-19 High Risk Exemption

Student name:	Campus:
---------------	---------

Return to in- person instruction medical certification exemption:

Should a student be identified to return to in-person instruction, but the student has a high-risk medical condition as defined by the Centers for Disease Control, a medical certification form will need to be completed.

This form will need to be presented at the appeal meeting or emailed to the campus administration to claim the high-risk exemption for COVID-19.

**Individual at Higher Risk:** Individuals at higher risk for severe illness from COVID-19 are those individuals with certain underlying health 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 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.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Health Care Provider

\_\_\_\_\_  
Date