



**Newark Community High School**  
**District No. 18**

413 CHICAGO RD., NEWARK, IL 60541  
 PHONE (815) 695-5164  
 FAX (815) 695-5752  
*Amy B. Smith, Superintendent*  
*James Still, Principal*

**REQUEST FOR FULL-TIME REMOTE LEARNING INSTRUCTION FOR FALL 2020**  
**MEDICAL REASON – DOCUMENT**

**\*In order to be considered for remote instruction, this form must be submitted on or before**  
**AUGUST 4, 2020.**

In light of the COVID-19 pandemic, the District has developed a full-time remote learning option for students with health conditions that cause them to be at higher risk of severe illness if exposed to COVID-19 or for students who live with an individual who has a health condition causing them to be at higher risk of severe illness if exposed to COVID-19. The District will consider requests for full-time remote instruction on a case by case basis. Any instructional days for approved full-time remote learning instruction will count as regular attendance days for the student. All approved requests for full-time remote instruction will apply for the duration of the semester, without the option to request to transition to in-person instruction until the next semester.

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

School: \_\_\_\_\_ Grade Level: \_\_\_\_\_

I, Parent/Guardian of the above-named student, acknowledge that I have reviewed the District's full-time remote learning plan for Fall 2020 and I request full-time remote learning instruction for my student for the entire fall semester of the 2020/2021 school year for the reason(s) outlined below [check all that apply]:

\_\_\_\_\_ **My student has a health condition that causes him/her to be at higher risk of severe illness if exposed to COVID-19.**

***If selecting this option, please check one of the following:***

- \_\_\_\_\_ Medical documentation from student's physician is attached.
- \_\_\_\_\_ Documented health or disability related condition is already contained in the student's education file at the District.

\_\_\_\_\_ **My student lives with an individual(s) who has a health condition that causes him/her to be at higher risk of severe illness if exposed to COVID-19.**

***If selecting this option, please attach the following:***

Medical documentation from household member's physician.

Please return this completed form to Mr. Jim Still, Principal or Mrs. Amy Smith, Superintendent. The District will review the information submitted and contact you regarding fall instruction, or for any additional information required to process this request.

\_\_\_\_\_  
 Signature of Parent/Guardian

\_\_\_\_\_  
 Date