**Verification of a Student Need for a Significant Medical Emergency Exemption**

**Submit this form only if one of the following apply**.

□ Exemption due to chronic absenteeism for medical reasons - requires a health provider's note excusing school attendance for 11 or more consecutive instructional days

□ \*Exemption due to doctor’s orders - requires doctor's orders not to test through at least the majority of a test window (Smarter Balanced, HSA Science (NGSS), HSA-Alt, Biology 1 EOC Exam (NGSS), The ACT, KAEO, ACCESS for ELs).
\* Exemptions from Smarter Balanced, HSA-Alt, or KAEO, effectively removes a student from Strive HI entirely.

Date:

Student Name: 10-digit Student ID: Grade Level:

School Name: School Code:

School Street Address (Street, City, Zip Code – No P.O. Box): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School Contact Person Name:

School Contact Person Telephone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School Contact Person E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Indicate assessment(s) for which the significant medical emergency exemption is being requested:

|  |  |
| --- | --- |
|  | □ Smarter Balanced ELA/Literacy □ Smarter Balanced Mathematics□ HSA Science (NGSS) □ Biology 1 EOC (NGSS) □ ACCESS for ELs □ HSA-Alt ELA □ HSA-Alt Mathematics □ HSA-Alt Science (NGSS) (grade 5, 8 or 11) |

**Significant Medical Emergency Required Evidence**

A healthcare provider (MD, OD, licensed psychologist, other provider) must write a note that includes the following information:

1. Student's Name.

2. General nature of the medical/psychiatric emergency.

3. Duration of the medical/psychiatric emergency for which absence from school and/or exemption from testing is ordered (must encompass the majority of the testing window for applicable assessment(s)).

4. Explanation stating that the student is excused from school and/or should not to be tested.

5. Provider's signature and date signed.

|  |
| --- |
| *Assessment Section Use Only*Verified: Y or NName and Date: |

In the event that the healthcare provider is reluctant to provide a note indicating that the student should not be tested prior to the end of a testing window, submit this form with the provider’s note after the testing window closes.

Email a scanned copy of the completed form to the Assessment Section at hsa-alt@k12.hi.us.

Or fax the completed form to the Assessment Section at (808) 733-4483.

The school Test Coordinator should retain the original form for documentation purposes.