

**Application for Carter Virtual School
Carter County Schools
Section I: Parent/Student Information**

2021

To be completed by the parent (s) /guardian (s) prior to full completion by the licensed medical or mental health professional.

School District _____ School _____ Grade _____
County of Residence _____ Last Date Attended _____
Student Receives Special Education Student _____ Yes _____ No _____
Name of Student _____ Date of Birth _____
Address of Student _____ Zip Code _____
Sex _____ Race _____ Social Security # _____ Telephone # _____
Full Name of Father/Guardian _____ Work Phone _____
Full Name of Mother/Guardian _____ Work Phone _____

List any special education programs in which your student may be enrolled:

List directions to student's home:

REQUIREMENTS AND UNDERSTANDING

I understand that the student must have and/or abide by the following in order to successfully succeed in Carter County Virtual Academy.

- Must be a resident of Carter County
- Must have a doctors statement
- Reliable Internet
- Work independently
- Remain in the virtual environment until the end of the semester that the student is enrolled in.
- Possess Strong Computer Skills
- Will not participate in any co-curricular activities (sports, prom, dances, clubs, etc.) addressed in the Carter County Virtual Academy Handbook.
- Follow all district guidelines for attendance and discipline. (Located in CCVA Student Handbook)

Parent/Guardian Signature

Date

Application for Carter County Virtual Academy

2021

Section II: Medical Professional Statement

This section is to be filled out by the authorized medical or mental health professional.

Name of Student _____

Please check **one** of the following:

☐ The student **can** attend school without any type of modifications or special provisions. Comments:

☐ The student is **unable** to attend school at this time due to health concerns connected to the COVID-19 virus, **I** support virtual learning instruction for this student. If you support virtual learning instruction at this time, please provide the following information:

Diagnosis and/or Reasoning: (Other than my personal opinion)

Additional Remarks/Comments:

As a Licensed Professional, are you aware of student school attendance or any truancy concerns?

Please check one: ☐ Yes ☐ No

Signature of Licensed Professional

Title

Date

****Please place your Certified Message Seal or Sticker on this form.***

Please Print or Type Name of Professional:

Office Address _____

Phone Number () _____

Fax Number () _____