MISSOURI DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
OFFICE OF QUALITY SCHOOLS – EDUCATIONAL SUPPORT SERVICES

MISSOURI VIRTUAL INSTRUCTION PROGRAM (MoVIP) MEDICALLY FRAGILE APPLICATION

DIRECTIONS

To be considered, a ***MoVIP Medically Fragile Application*** must be completed and mailed, scanned, and/or emailed to:

Missouri Department of Elementary and Secondary Education (DESE), Missouri Virtual Instruction Program (MoVIP), P.O. Box 480, 205 Jefferson St., Jefferson City, MO 65102-0480

Email: movipinfo@dese.mo.gov, Phone: (573) 751-2453, Fax: (573) 522-1134

Applications must be signed by both the parent and physician to be valid.

ADDITIONAL INFORMATION

1. The medically fragile seats in MoVIP are not for temporary medical conditions (six (6) weeks or less).
2. Students who apply and are accepted into the medically fragile program are expected to participate for an entire semester.
3. Students must participate in the required Missouri Assessment Program (MAP) tests and End-of-Course (EOC) exams as applicable. Transportation must be provided by the parent/guardian to a location specified by MoVIP. Failure to participate may disqualify the student for future MoVIP enrollments.
4. If sufficient funds are not available to meet demand, priority will be given to medically fragile students who absolutely cannot attend school for medical reasons.
5. Interested students who do not qualify as medically fragile may attend MoVIP by paying tuition.

PERSONAL INFORMATION

DATE OF APPLICATION:	MOVIP STUDENT STATUS: ☐ NEW ☐ EXISTING		
LAST NAME OF STUDENT:	FIRST NAME OF STUDENT:	DATE OF BIRTH:	GENDER:
ETHNICITY: ☐ HISPANIC/LATINO ☐ NOT HISPANIC/LATINO	RACE (CHECK ALL THAT APPLY): ☐ BLACK/AFRICAN AMERICAN ☐ AMERICAN INDIAN OR ALASKIN NATIVE ☐ NATIVE HAWAIIAN OR PACIFIC ISLANDER ☐ WHITE ☐ ASIAN		
PARENT/GUARDIAN LAST NAME:	PARENT/GUARDIAN FIRST NAME:	RELATIONSHIP TO STUDENT:	COUNTY OF RESIDENCE:
PRIMARY PHONE:	SECONDARY PHONE:	WORK PHONE:	
HOME ADDRESS:	CITY:	STATE:	ZIP:
PARENT/GUARDIAN EMAIL ADDRESS:	STUDENT EMAIL ADDRESS:		
SCHOOL TYPE: ☐ PUBLIC ATTENDING MOVIP ☐ PRIVATE ATTENDING MOVIP ☐ MOVIP ONLY			
YEAR EXPECTED TO GRADUATE:	PUBLIC SCHOOL DISTRICT OF RESIDENCE:	IEP: ☐ YES ☐ NO 504: ☐ YES ☐ NO	LIMITED ENGLISH PROFICIENCY (LEP): ☐ YES ☐ NO
Does the student's physical or mental condition prevent the student from attending his/her local public school? ☐ YES ☐ NO			
How many courses do you plan to enroll in for the 1st semester?	How many courses do you plan to enroll in for the 2nd semester?		
Students must participate in the Missouri Assessment Program (MAP) tests and/or End of Course (EOC) exams as applicable. Transportation must be provided by the parent/guardian to a location specified by MoVIP. I understand that my child must participate in testing as applicable. Failure to participate may disqualify the student for future MoVIP enrollments.			
PARENT/GUARDIAN SIGNATURE:	DATE:		

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MEDICAL INFORMATION (TO BE COMPLETED BY PHYSICIAN)

1. Does the student's medical or psychological diagnosis prevent the student from attending school in the community? ☐ Yes ☐ No

2. Please explain the student's medical or psychological diagnosis. Please include the date of onset and estimated time for recovery. Attach an additional sheet if necessary.

3. Recommendations and explanations of diagnosis: Please describe why the student cannot attend school in the local district.

4. Is there anything about the student's medical or psychological diagnosis that would prevent the student from participating in and benefiting from virtual education? Please explain. (Virtual education is defined as courses conducted on-line with interaction with teachers via email/telephone—no set class periods but deadlines for completion within the semester).

PHYSICIAN INFORMATION

Note: This section must be signed by one of the four medical professionals listed below. Another medical professional's signature, acting on their behalf, is not acceptable.

Indicate area of licensed specialty: ☐ Medical Doctor (M.D.) ☐ Doctor of Osteopathic Medicine (D.O.) ☐ Psychiatrist ☐ Psychologist

PHYSICIAN SIGNATURE:	PRINT PHYSICIAN'S NAME:			DATE:
ADDRESS OF PHYSICIAN:	CITY:	STATE:	ZIP:	PHONE:

NOTICE OF AWARD (DESE USE ONLY)

APPROVED BY DESE

NAME:	TITLE:	DATE: