ST. JOHN SCHOOL
VOLUNTARY MEDICAL DISCLOSURE

I, the undersigned, am the parent/guardian of the student listed below, and would like to voluntarily disclose the following medical conditions that affect my student because they may present the same symptoms that are associated with Covid-19 and/or may put my student in an increased-risk category for Covid-19 according to the CDC. I understand that this information will be kept confidential, and will only be used by the school in efforts to discern the appropriate response for my student and the rest of the St. John community should my student show symptoms of Covid-19 while at school.

Name of Student: ______________________________ Grade: __________________________

Medical Conditions:

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_____ My student takes prescription medication regularly for one or more of the above conditions. (If yes, please list the medications above with the conditions, or attach a list to this form.)

______ My student takes over-the-counter medications or uses other non-prescription treatments as needed for all of the above conditions.

______ I can provide documentation from my student's pediatrician/physician confirming the above condition(s) upon request from the school and will voluntarily do so if requested.

Parent Signature: _________________________________ Date: _______

Print Name: ____