

CUBA-RUSHFORD CENTRAL SCHOOL

Superintendent of Schools, 585-968-2650 / Fax: 968-2651

Director of Special Education 585-968-1760 Ext.3222

Middle/High School
5476 Route 305N, Cuba, NY 14727
585-968-2650 / Fax: 968-2651

Elementary School
15 Elm Street, Cuba, NY 14
585-968-1760 / Fax: 968-8571

Cell Phone Use for Medical Reasons Request Form

Students without a 504 or IEP Medical Accommodation

For Parent/Guardian and Physician Completion

Student Information

- Student Name: _____
- Grade: _____
- School Name: _____
- 1st Period/Teacher: _____

Parent/Guardian Information

- Parent/Guardian Name: _____
- Phone Number: _____
- Email Address: _____

Medical Information

- **Medical Condition Requiring Phone Access:**
(e.g., Diabetes, Seizure Disorder, Asthma)
 - **Reason for Phone Use During School Hours:**
(e.g., monitoring health via app, emergency contact, medication reminders)
 - **Phone Use Details**
 - **Device Type:** Cell Phone Smartwatch Other: _____
 - **Requested Access During:**
 - Class time
 - Passing periods
 - Lunch
 - As needed for medical alerts
 - Other: _____
 - **Apps/Devices to Be Used for Medical Monitoring:**
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Parent/Guardian Justification:

Parent/Guardian Consent

I request that my child be permitted to carry and use a personal device at school for medical reasons. I understand this access is solely for health-related purposes, and misuse may result in revocation.

Parent/Guardian Signature: _____

Date: _____

Physician's Statement & Authorization

I confirm that the above-named student is under my care and requires access to a personal device during school hours for medical monitoring or health-related communication.

- **Student's Medical Condition:**
- **Medical Necessity for Device Access at School:**
- **Recommended Times for Device Access:**
 - As needed
 - Specific times: _____
- **Recommended Apps or Monitoring Tools:**

I recommend that the student be allowed to use a device during school hours for health-related purposes as part of their medical care plan.

Physician's Name: _____

Office Phone: _____

Office Address: _____

Signature: _____

Date: _____

Please return to Larissa B. Brady, Director of Special Education, via email at lbrady@mycrs.org