Request for Medical Exemption to Face Covering Requirements

If your child is unable to wear a face covering in school due to a medical or mental health condition or disability, you must provide to the school Principal/Nurse at your child's school building, this form signed and dated from your child's physician (referred to below as "healthcare provider"). This form must specify the medical or mental health condition or disability that precludes your child from wearing a face covering in school, as well as suggestions for alternative means for your child for preventing the spread of the virus.

A physician is defined as an M.D. for Doctor of Medicine or D.O. for Doctor of Osteopathic Medicine. Medical notes from alternative health providers, such as Chiropractors, etc., will not not be accepted.

Additionally, the School will require students with a Medical Exemption to Mask Requirements to remain at least 6 feet apart from other individuals for social distancing while indoors in accordance with the Centers for Disease Control guidelines and local Health Department mandates.

A School reserves the right to not accept a Request for Medical Exemption to Mask Requirements.

A School may require that a child wear a face shield when social distancing is not possible.

The parent will need to submit this informational sheet signed, with the documentation from the physician when requesting a Medical Exemption to Mask Requirements.

Parent Signature _____

Date _____

SECTION A. To be completed by your child's parent/guardian.

Full Name of Child: _____

School: _____

Grade for 2021-2022 School Year: _____

I am requesting an exemption from the mask requirements due to my understanding that my child has a documented medical or mental health condition or disability that precludes the wearing of a face covering in school, and I am requesting an exemption from this requirement.
I understand that:

1. By not wearing a face covering in school, my child may be at increased risk of contracting or spreading COVID-19;
2. The school may consider appropriate alternative learning options for my child, including whether virtual learning is appropriate;
3. My child may be referred for an evaluation to determine if any disability prevents my child from wearing a face covering and whether and to what extent accommodations will be provided;
4. Submitting this form constitutes my permission for the School to communicate with my child's healthcare provider regarding this medical or mental health condition or disability; and
5. Submitting this form does not guarantee that my medical exemption request will be granted. The School must first review my request and provide notification if it is granted.

_____ _____

Parent/Guardian Name (Print) **Parent/Guardian Signature**

SECTION B. To be completed by your child's healthcare provider.

Full Name of Healthcare Provider: _____

Office Address: _____

Telephone Number: _____

Full Name of Patient (the child): _____

Subject to the penalties of unsworn falsification to authorities, I hereby certify that it is my professional opinion, with a reasonable degree of professional certainty, that [check the box that applies]:

☐ My patient (the child) does NOT have any medical or mental health condition or disability that precludes the wearing of a face covering in school;

☐ My patient (the child) has a medical or mental health condition or disability that relates to his or her wearing a face covering in school, but he or she can tolerate wearing a face covering in school if accommodations are provided. The recommended accommodations are (specify):

_____
_____
_____

☐ My patient (the child) has a medical or mental health condition or disability that precludes the wearing of a face covering in school.

If you checked either the second or third box, please identify the medical or mental health condition or disability and specify how that relates to your patient's (the child's) ability to wear a face covering in school:

_____
_____
_____

If you checked either the second or third box, please specify any and all alternative means that may be used by your patient (the child), while your patient (the child) is not wearing a face covering in school, to protect your patient (the child) and others from, and to prevent the contraction and spread of, COVID-19 in school:

_____
_____
_____ _____

_____ _____
Physician Signature **Date**

_____ _____
Office Address **Phone Number**

_____
Email Address