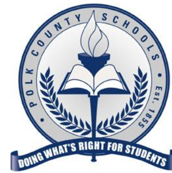
COVID-19 FACE COVERING REQUIREMENT EXCEPTION REQUEST FORM FOR STUDENTS



COVID-19 GUIDANCE I Last updated 9/7/21

All students in Polk County Schools (PCS) buildings are expected to wear face coverings during the instructional day and when participating in instructional activities, except when actively eating or drinking, while involved in strenuous exercise, or during designated mask breaks. Requests for exceptions to this rule will be considered on a case-by-case basis for students with a medical, psychological, or behavioral condition or disability that renders mask-wearing harmful or medically inadvisable. Documentation from a licensed healthcare provider will be required to support an exemption request. Students with exceptions may be required to quarantine up to 14 days if they are exposed in the school setting unless the student is asymptomatic and has been vaccinated or positive in the last 90 days.

INSTRUCTIONS: *If you are a parent or legal guardian of a student whom you identify as unable to comply with the face covering requirement and you are requesting an exemption for your student, please use this form to make the request and ask your child's current medical provider to complete the certification portion.* ***Requests should be submitted to your student's principal.***

Student Name	Student ID Number	Student Date of Birth

Home Address	School/Grade

Student Currently Has:

- ☐ Individualized Education Program (IEP)
- ☐ Section 504 Plan
- ☐ Health Plan
- ☐ N/A

Reason for exception request:

Student Name ___________________________________

Parent Consent for Two Way Communication	
I consent to the release of related medical documentation and authorize the medical provider identified below to discuss the condition with PCS officials.	
Parent/Guardian Name (please print)	Signature of Parent/Guardian
Date:	Parent Telephone:

Medical Certification (to be completed by Licensed Healthcare Provider)

As the student's healthcare provider, I certify that this student has a physical, medical, or psychological impairment that substantially limits a major life activity AND this condition interferes with the student's ability to wear a face covering during school hours.

- ☐ Yes
  - ☐ ***I will make myself available to meet with school officials, if deemed necessary, to review the student's medical needs***
- ☐ No

Please identify the medical condition and how it impacts the student's ability to wear a face covering:

Recommendation: *Please indicate 1, 2, or 3:*

- ☐ 1. The student is incapacitated to the extent of being unable to remove a face covering without assistance.
- ☐ 2. A face covering could cause harm, is inadvisable/impracticable, or dangerously obstructs breathing at ALL times.
- ☐ 3. Face coverings can be worn to some extent, but due to the student's condition I recommend:
  - ☐ Breaks from face covering in addition to those already built into the school day (breakfast, lunch, outdoor recess)
  - ☐ Removal if respiratory distress occurs
  - ☐ For student to be excused from wearing a face covering during certain specific activities

    Specify activities:
  - ☐ Use of an alternative or modified face covering (identify modification)

Name of Health Care Provider (Print):	Signature of Health Care Provider:
Date:	Telephone:

Student Name ___________________________________

For Polk County Schools staff use only	
☐ Request is approved ☐ Request is denied ☐ No medical documentation ☐ More information needed - please specify below:	
District Health Director / School Nurse	Date
Principal or Principal Designee	Date