ARCADIA PUBLIC SCHOOLS

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REQUIRED MASK/FACE COVERING WAIVER

If your child is unable to wear a mask or face covering due to a medical or mental health condition or disability, you must provide to the school administration, this form signed and dated from your child's physician. This form must specify the medical or mental health condition or disability that precludes your child from wearing a mask or face covering in school and on school transportation, 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. Doctor of Osteopathic Medicine. Medical notes from alternative health providers, such as Chiropractors, etc., will not be accepted.

Additionally, Arcadia Public School will require students with a medical exemption to wear a mask or face covering to remain at least six (6) feet apart from other individuals for social distancing while indoors in accordance with Centers for Disease Control guidelines and Loup Basin Public Health department guidelines.

Arcadia Public School reserves the right to not accept a request for medical exemption to mask or face covering requirements.

Arcadia Public School may require a child to 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 or face covering requirements.

_____ _____

Parent Signature **Date**

Section A – To be completed by the child's parent(s)/legal guardian(s).

Full Name of Child: _____

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

1. By not wearing a mask or face covering in school or on school transportation, 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 mask or face covering and whether and to what extent accommodations will be provided;
4. Submitting this for constitutes my permission for Arcadia Public School to communicate with my child's healthcare provider regarding this medical or mental health condition or disability; and
5. Submitting this for does not guarantee that my medical exemption request will be granted. Arcadia Public School must first review my request and provide notification if it is granted.

_____ _____

Parent/Guardian Name (printed) **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 penalties of unsworn falsification to authorities, I hereby certify that it is my professional opinion, with reasonable degree of professional certainty, that [mark the selection that applies]:

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

_____ My patient (the child) has a medical or mental health condition or disability that relates to his or her wearing of a mask or face covering in school or on school transportation, but he or she can tolerate wearing a mask or face covering in school or on school transportation 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 mask or face covering.

If you checked either the second or third selection, 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 mask or face covering in school or on school transportation:

_____

_____

_____

If you checked either the second or third selection, 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 mask or face covering in school and on school transportation, to protect your patient (the child) and others from, and to prevent the contraction and spread of COVID-19 in school or on school transportation::

_____

_____

_____

_____ _____

Physician Signature Date