2021/22 SCHOOL YEAR
MEDICAL EXEMPTION / ACCOMMODATION REQUEST:
FACIAL COVERING

Part 1 - To be completed by Parent/Guardian

Student's Name _____ Birthdate _____ Grade _____

Address_____
Street City Zip Code

Parent/Guardian's Name _____ Phone # _____

School Last Attended _____ Last Day Attended _____

Teacher/Counselor_____

Name of Licensed Health Care Practitioner providing the recommendation: _____

Phone # _____

Reason for Medical Exemption Request: Face Mask / Face Shield *(circle one or both)*

Release and Exchange of Information: Referring to the above-named person, I hereby request and authorize the release/exchange of medical, psychological, family and social information to Achieve Charter School

_____
Parent/Guardian Signature Date

Part 2 - To be completed by Licensed Health Care Practitioner

A Medical Exemption for face covering use is being considered for the student named above. Medical Exemptions may be considered for students with a disability or medical condition that prevents the wearing of a face mask or face shield. Advice from a Licensed Health Care Practitioner is necessary in determining how the school can best accommodate the needs of the student, and in particular, whether the student is able to wear a face mask and/or face shield.

Student's Name _____ Date _____

Diagnosis/Comments and Recommended Accommodation:

_____

_____

Medical Exemption for Face Mask recommended? ☐ NO ☐ Yes

Medical Exemption for Face Shield recommended? ☐ NO ☐ Yes

Probable length of time the accommodation will be needed: start date _____ end date _____

Please note student limitations and/or health precautions :

_____

_____

Printed Name of the Licensed Health Care Practitioner _____

Health Care Practitioner Professional License Number _____

_____

Licensed Health Care Practitioner Signature Date

Part 3 - To be completed by School Site Administrator

Student ID# _____

Medical Exemption for ***Face Mask*** Approved? ☐ NO ☐ Yes

Medical Exemption for ***Face Shield*** Approved? ☐ NO ☐ Yes

Accommodation Noted in Aeries: ☐ NO ☐ Yes

_____

Nurse Name Nurse Signature Date

Attach (if applicable):

- *IEP copy and/or 504 Plan*