REQUEST FOR ACCOMMODATIONS TO FACE COVERING POLICY DUE TO MEDICAL CONDITION

STUDENT'S NAME_____ D.O.B. _____

Pursuant to IDPH and ISBE joint guidance, as well as District Policy, any individual present in any building, facility or transportation vehicle (i.e. bus) owned, operated or used by the District, shall at all times wear a face covering, even when social distancing is maintained. A "face covering" is defined as "a cloth face covering, N95 mask, surgical mask, or other material that fully covers the nose and mouth and is approved by the Centers for Disease Control and Prevention." Individuals who cannot wear a face covering due to a medical condition may request a reasonable accommodation. Requests for reasonable accommodations due to a medical condition must be completed and signed by the student's physician or other qualified health care provider.

I. BACKGROUND INFORMATION - TO BE COMPLETED BY STUDENT'S PARENT/GUARDIAN

Basis of Request for Accommodation to Face Covering Policy:

_____

Explanation of Steps Taken to Acclimate Student to Wearing Face Covering and Student Response (if applicable):

_____

_____.

II. MEDICAL CERTIFICATION — TO BE COMPLETED BY THE STUDENT'S QUALIFIED HEALTH CARE PROVIDER

Diagnosis and/or Description of Medical Condition Preventing the Student from Wearing a Face Covering:

_____

_____.

Impact Student's Medical Condition Has on Student's Ability to Wear a Face Covering:

_____

_____

_____.

Suggested Alternative(s) to Wearing Face Covering to Address IDPH and CDC Health and Safety Guidelines:

_____

_____.

Any Additional Relevant Information on the Diagnosed Medical Condition (optional):

_____

_____.

Signed:

_____ _____ _____

Signature of Qualified Health Provider | Date | Phone Number

_____ _____

Print Name of Qualified Health Provider | Address of Qualified Health Care Provider

III. CONSENT FOR RELEASE - TO BE SIGNED BY STUDENT'S PARENT/GUARDIAN

I authorize the District and the Qualified Health Care Provider listed above to mutually exchange information, including conversations, concerning my student's medication condition and the impact of such on my student's compliance with the District's face covering policy.

This authorization is valid until _____ unless otherwise revoked in writing. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I understand that my revocation of this authorization will not be effective for actions taken by the school district or the designated individual/agency in reliance upon my authorization and prior to notice of my revocation. I understand that failing to authorize disclosure of information may impact the District's ability to grant my request for reasonable accommodations. I recognize that health records, once received by the school district, may not be protected by the HIPAA Privacy Rule, but will become education records protected by the *Family Educational Rights and Privacy Act* and the *Illinois School Student Records Act*. I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain a free appropriate public education.

Parent Name: _____ Date: _____

Parent Signature: _____

*Parent/Guardian—Please return this completed form to the building principal so the student's school team or IEP team may consider the request for accommodations.