San Diego & Imperial Valley
CATHOLIC SCHOOLS

2021-2022 Student Mask Exemption Request & Medical Certification Form

K-12 students are required to mask indoors in school settings, with exemptions per CDPH face mask guidance. Parents/guardians of a student with a medical condition, mental health condition, or disability that prevents wearing a mask may request an exemption per *California Department of Public Health (CDPH) guidelines*.

According to CDPH guidelines:

- *K-12 students are required to mask indoors, with exemptions per CDPH face mask guidance.*
- *Persons exempted from wearing a face covering due to a medical condition, must wear a non-restrictive alternative, such as a face shield with a drape on the bottom edge, as long as their condition permits it.*

In connection with the COVID-19 pandemic, CDPH requires students to wear face coverings while in attendance in-person at school to the extent required by applicable federal, state, or local laws, regulations, ordinances, emergency orders, or state/local schools board action.

CDPH recognizes that some students may have disabilities, medical conditions or mental health conditions for whom wearing a face covering may cause harm or obstruct breathing and thus for which an exemption may be obtained. Please note that asthma and allergies generally do not qualify for a medical exemption.

This Exemption Request must be completed in its entirety by the parent/guardian, and Medical Provider and submitted to the Administrator of the student's school of attendance. Incomplete Exemption Requests will be returned to the parent/guardian for completion.

Instructions:

- Parent/Guardian completes Part 1
- Student's Medical Provider completes Part 2
- Submit the completed forms to the administrator of the student's school of attendance

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Part 1: To be Completed by Parent/Guardian _

**Field must be completed or the form will be considered incomplete*

Parent/Guardian's Name filling out this form:*_____

Phone # *_____ Email:* _____

Student Name *	Student ID Number *	Student Date of Birth *
Home Address *		School/Grade *

Parent/Guardian Consent to Face Covering Exemption (Please Initial)	
____ I understand that according to CDPH, masks are one of the most effective and simplest safety mitigation layers to prevent in-school transmission of COVID-19 infections. *	
____ I understand that according to CDPH, if a mask medical exemption is granted, the following option per CDPH guidance is available: Face shield with drape. *	
____ I understand that according to CDPH, if the mask exemption is NOT granted, I must send my child to school with a mask. *	
Parent/Guardian Name (print) *	Date *
Parent/Guardian Signature *	

Parent/Guardian Consent for Release and Exchange of Information	
I affirm that my child has been diagnosed with the medical condition, mental health condition, and/or disability described below. I consent to the release of related medical documentation and authorize the medical provider identified below to discuss the condition with *_____. (Name of School)	
Parent/Guardian Name *	Parent Telephone *
Signature of Parent/Guardian *	Date *

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Part 2: To be Completed by Medical Provider

**Field must be completed or the form will be considered incomplete*

Medical Certification
• *As the student's health care provider, I certify that this student has a medical or mental health condition, and/ or disability and that a face covering may cause harm or obstruct breathing which makes it inadvisable or impracticable for the student to wear. Examples include, but are not necessarily limited to: respiratory impairments, hearing impairments requiring the use of facial/mouth movements, physical impairments that make it difficult to easily wear or remove a face covering, sensory impairments, etc.*
I certify that this student has a:* Medical Condition Mental Health Condition Disability Based on the nature of this student's impairment indicated above: Student is medically unable to wear a mask and must wear a non-restrictive alternative, such as a face shield with a drape on the bottom edge, as long as their condition permits it. Additional recommendations:_____

Name of Medical Provider (Print):*	Medical License #: * Type of Provider (PA, MD, NP, DO, etc…):* *Must be a California Licensed healthcare provider in good standing.*
Signature of Medical Provider *	Date: *
Address: *	Telephone: *