PUTNAM COUNTY SCHOOL DISTRICT
SHAPING THE FUTURE

COVID-19 FACE COVERING OPT-OUT FORM

Instructions: Parent/Guardian will complete top portion, and licensed heath care provider will complete bottom portion. Return this form to the administrative staff of your child's school.

PCSD Face Covering Requirement:

Beginning September 1, 2021, face coverings are required for students and staff while riding in all PCSD buses and vehicles. Face coverings are encouraged, but optional, inside all PCSD schools and facilities.

A face covering WILL NOT be required for persons who provide this COVID-19 Face Covering Opt-Out Form from a licensed health care provider stating that the person has a medical, physical, or psychological condition that prevents the person from being able to safely wear a face covering. A licensed health care provider means any provider of health care services who is licensed or certified by the applicable governmental regulatory authority to the extent that services are within the scope of the license or certification.

By filling out the form below, I am requesting that my child be released from the COVID-19 face covering requirement. I understand that pursuant to section 768.38, Florida Statutes, an educational institution is not liable for damages, injury, or death arising from or related to COVID-19, provided it made a good faith effort to substantially comply with one or more sources or set of health standards or guidance that was authoritative or controlling at the time the cause of action is alleged to have occurred**.**

Student Name: _____ **Date of Birth:** _____

School: _____ **Grade Level:** _____

As the parent/guardian of the student named above, I hereby request that my child be released from the PCSD COVID-19 face covering requirement based on a medical need as certified by a licensed health care provider below.

Parent/Guardian Name (Print): _____

Parent/Guardian Signature: _____ **Date:** _____

FOR LICENSED HEALTH CARE PROVIDER ONLY (physician/psychologist, etc.)

I certify that _____ **should NOT wear a face covering due to a**
Student First & Last Name (Print)

medical, physical, or psychological condition.

Licensed Health Care Provider Name (Print): _____

Health Care Provider License #: _____ **Provider Phone #:** _____

Licensed Health Care Provider Signature: _____ **Date:** _____

Form Updated 9/7/21