

MEDICAL EXEMPTION FOR FACE MASKS

STUDENT NAME: _____ DOB: _____

PARENT/GUARDIAN NAME: _____

ADDRESS: _____

PARENT PHONE: _____ PARENT E-MAIL _____

TO BE COMPLETED BY PHYSICIAN:

REASON FOR EXEMPTION/DIAGNOSIS: _____

CAN MASK WEARING RESUME AT A LATER DATE? YES ___ NO ___ DATE _____

PHYSICIAN SIGNATURE: _____

OFFICE: _____ PHONE: _____

PARENT/GUARDIAN SIGNATURE: _____

SCHOOL NURSE SIGNATURE: _____

***This form must be returned to the school nurse.