

**Springfield School District**  
**Student Face Covering - Medical or Mental Health Exemption Request**

Please note that the June 1, 2021, updated Order from the Secretary of the Pennsylvania Department of Health requiring Universal Face Coverings **does not change** school-based practices around face-covering requirements. Exemptions from wearing face-coverings in the school setting still must adhere to the updated order which continues the same practices as outlined in July 1, 2020 and August 17, 2020. Therefore, all students continue to be required to wear face coverings at all times in school except when eating or drinking when spaced at least 6 feet apart; or when wearing a face covering creates an unsafe condition in which to operate equipment or execute a task; or when at least 6 feet apart during “face-covering breaks” to last no longer than 10 minutes; or unless they have a documented medical or mental health condition or disability that precludes the wearing of a face covering in school.

<https://www.health.pa.gov/topics/disease/coronavirus/Pages/Guidance/Universal-Masking-FAQ.aspx>

If you believe that your child has a **documented** medical or mental health condition or disability that precludes the wearing of a face covering in school, and you are requesting an exemption from this requirement, you must have this two-page form fully completed and submitted to the school nurse at your child’s school building.

**THIS FORM MUST BE FULLY COMPLETED BY YOUR CHILD’S PARENT/GUARDIAN AND HEALTHCARE PROVIDER FOR YOUR REQUEST TO BE CONSIDERED BY THE DISTRICT.**

**SECTION A. To be completed by your child’s parent/guardian.**

**Full name of child:** \_\_\_\_\_

**School building:** \_\_\_\_\_

**Grade for 2020-2021 school year:** \_\_\_\_\_

I believe that my child has a documented medical or mental health condition or disability that precludes the wearing of a face covering in school, and I am requesting an exemption from this requirement. I understand that:

1. by not wearing a face covering in school, my child may be at increased risk of contracting or spreading COVID-19;
2. the school may consider appropriate alternative learning options for my child, including whether virtual learning is appropriate;
3. my child may be referred for an evaluation to determine if any disability prevents my child from wearing a face covering and whether and to what extent accommodations will be provided;
4. **submitting this form constitutes my permission for the District to communicate with my child’s healthcare provider regarding this medical or mental health condition or disability; and**
5. submitting this form does not guarantee that my exemption request will be granted. The District must first review my request.

\_\_\_\_\_  
**Parent/Guardian Name (Print)**

\_\_\_\_\_  
**Parent/Guardian Signature**

\_\_\_\_\_  
**Date**

**PLEASE PROCEED TO PAGE 2 OF 2 OF THIS FORM.**

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**SECTION B. To be completed by your child's healthcare provider.**

**Full name of healthcare provider:** \_\_\_\_\_

**Office address:** \_\_\_\_\_

**Telephone number:** \_\_\_\_\_

**Full name of your patient (the child):** \_\_\_\_\_

Subject to the penalties of unsworn falsification to authorities, I hereby certify that it is my professional opinion, with a reasonable degree of professional certainty, that [check the box that applies]:

- My patient (the child) does **NOT** have any medical or mental health condition or disability that precludes the wearing of a face covering in school;
  
- My patient (the child) has a medical or mental health condition or disability that relates to his or her wearing a face covering in school, but he or she can tolerate wearing a face covering in school if accommodations are provided. These accommodations are (specify):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
  
- My patient (the child) has a medical or mental health condition or disability that precludes the wearing of a face covering in school.

**If you checked either the second or third box, please identify the medical or mental health condition or disability and specify how that relates to your patient's (the child's) ability to wear a face covering in school:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**If you checked either the second or third box, please specify any and all alternative means that may be used by your patient (the child), while your patient (the child) is not wearing a face covering in school, to protect your patient (the child) and others from, and to prevent the contraction and spread of, COVID-19 in school:**

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**Healthcare provider signature**

\_\_\_\_\_  
**Date**