GLENDALE SCHOOL DISTRICT
PARENT REQUEST
STUDENT MASK/FACE COVERING EXEMPTION

The Pennsylvania Department of Health declared a mask/face covering mandate for all public and private school students in the Commonwealth of Pennsylvania effective September 7, 2021. The Order allows for a medical exemption where "wearing a face covering would either cause a medical condition or exacerbate an existing medical condition including respiratory issues that impede breathing, a mental health condition or disability. Students not wearing a mask/face covering and who do not otherwise have a medical exemption on file will be asked to comply with the face covering requirement. I understand that my not wearing a mask/face covering, _____ is potentially at a higher risk of COVID-19 exposure. I also understand that if my child is not wearing a mask/face covering and is identified as being a close contact, my student will be quarantined for 7-10 days unless vaccinated and asymptomatic. I agree to comply with all other COVID-191 mitigation strategies including keeping my student home if there are any signs of illness.

The Medical Certification completed in full by the student's medical or mental health provider must be submitted to the school nurse for review within 5 calendar days of the parent/guardian submitting the Parent Request for an exemption from the Order for medical reasons. The medical or mental health provider must be licensed and qualified to diagnose the disability or condition preventing the student from safely wearing a mask/face covering. For the purposes of a mask/face covering exemption request, licensed providers shall include licensed physicians, psychiatrists, and psychologists. Parents/guardians will be notified of approval/denial of the Exemption Request.

STUDENT NAME: _____
DOB:_____ GRADE:_____
PARENT/GUARDIAN NAME:_____
MY CHILD MEETS THE MEDICAL EXEMPTION TO THE FACE COVERING REQUIREMENT BECAUSE:_____
_____
_____

I understand that the School District must evaluate all available evidence to determine whether _____ has a medical condition or disability that would entitle him/her to the protections of 504 of the Rehabilitation Act of 1973. I agree to submit the Medical Certification from my child's physician within 5 calendar days of submission of this request to certify the condition referenced above and describe how the medical condition impacts _____'s ability to comply with the Mask/Face Covering Order.

I affirm that the above information is true and correct and that I am providing the information contained herein under penalty for making unsworn falsification to public officials, 18 Pa.C.S. §4904.

_____ (Parent Signature) Date:_____
_____ (Parent Name-Print)

FORM 1 OF 2 FOR MEDICAL EXEMPTION

GLENDALE SCHOOL DISTRICT
MEDICAL CERTIFICATION
STUDENT MASK/FACE COVERING EXEMPTION

The Pennsylvania Department of Health declared a mask/face covering mandate for all public and private school students in the Commonwealth of Pennsylvania effective September 7, 2021. The Order allows for a medical exemption where "wearing a face covering would either cause a medical condition or exacerbate an existing medical condition including respiratory issues that impede breathing, a mental health condition or disability.

This form must be completed in full by the student's medical or mental health provider and submitted to the school nurse for review within 5 calendar days of the parent/guardian submitting a request for an exemption from the Order for medical reasons. The medical or mental health provider must be licensed and qualified to diagnose the disability or condition preventing the student from safely wearing a mask/face covering. For the purposes of a mask/face covering exemption request, licensed providers shall include licensed physicians, psychiatrists, and psychologists. Parents/guardians will be notified of approval/denial of the Exemption Request.

PART I: STUDENT INFORMATION

NAME:_____

DOB:_____ GRADE:_____

PARENT/GUARDIAN NAME:_____

PART II: MEDICAL CERTIFICATION TO BE COMPLETED BY THE MEDICAL OR MENTAL HEALTH PROVIDER

I certify that the above-named student is under my care and has the following diagnosis or condition:_____

_____

As a result of the aforementioned diagnosis or condition, in my professional opinion, the student is not able to wear a mask/face covering or is unable to wear a mask/face covering safely as outlined by the Centers for Disease Control and Prevention.

_____Agree _____Disagree

Wearing a mask/face covering would impact the Student's medical/mental health condition as follows:_____

_____

I certify that the information provided above is truthful and that, in my professional medical opinion_____ has the above-explained condition and limitations and requires the recommended accommodation.

_____ (Provider Signature) Date:_____

_____ (Provider Name-Print)

_____(Provider Professional License)

_____(Provider Phone Number)

FORM 2 OF 2 FOR MEDICAL EXEMPTION