

COUNCIL ROCK SCHOOL DISTRICT
Request for Medical Exception from Face Covering Requirement

Name of Student _____ School _____ Grade _____

Address _____ Phone _____

Date of Birth _____ Parent Email _____

Parent/Guardian Must Complete This Section:

Please check the appropriate box:

Wearing a face covering would cause a medical condition.

Wearing a face covering would exacerbate a current medical condition.

Wearing a face covering would exacerbate a current mental health condition.

Wearing a face covering would exacerbate a current disability.

All alternatives to a face covering, including the use of a face shield, have been exhausted.

Yes

No

I hereby certify that I have completed this form truthfully and accurately, that the requested exception is medically necessary for my child and that all alternatives to a face covering, such as a face shield, have been exhausted.

Parent/Guardian Name

Parent/Guardian Signature

Date

Approved Date: _____