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Face Covering/Shield Exemption Form

INTRODUCTION

A student in grades K-12 may be exempt from the requirement to wear a "face covering" at school if a "medical authority" certifies that the student has a health condition, disability, or mental health, developmental, or behavioral need that makes a student unable to tolerate wearing a face covering. A student will then be expected to wear a face shield unless a medical authority certifies that the student is unable to tolerate a face shield because of a medical condition.

- "Face covering" means any paper or disposable mask, cloth face mask, medical-grade mask, scarf, bandanna, neck gaiter, or religious face covering that can be worn to cover the nose and mouth completely in accordance with CDC guidance. Masks with valves, mesh, openings, holes, vents, or visible gaps in the material are not sufficient face coverings.
- "Face shield" is a clear plastic barrier that covers the face, extends below the chin, and wraps around the sides of the face to the ears. An adequate face shield should have no exposed gap between the forehead and the shield's headpiece.
- "Medical authority" means a medical doctor, clinical psychologist, physician assistant, or nurse practitioner who has seen or treated the student.

If you believe that your child is exempt from wearing a "face covering" and/or "face shield," you must sign this form and have a "medical authority" sign and complete this form. An exception will be made if the need for an exemption is obvious or the St. Croix Preparatory Academy already possesses information that demonstrates the need for an exemption.

This form must be given to the Licensed School Nurse. St. Croix Preparatory Academy will make the final determination of whether the student qualifies for an exemption.

FORM

TO BE COMPLETED BY PARENT/GUARDIAN

Student Name: ____ Date of Birth: ___________________________

Address: ____ School of Attendance: __________________

I certify that the information on this form is true and accurate to the best of my knowledge.

Parent Signature: ____ Date: ______________________________

TO BE COMPLETED BY MEDICAL AUTHORITY

Print Name: ___________________________________ Name of Clinic: _________________________________

Clinic Address: _______________________________ Clinic Phone: __________________________________

Based on personal knowledge from examining, treating, or reviewing the medical records of the student who is identified above, I certify that the following is true and accurate (check those that apply and identify condition):

☐ The student is unable to tolerate wearing a face covering at school because of the following health condition, disability, or mental health, developmental, or behavioral need:

____

☐ The student is unable to tolerate a face shield at school because of the following medical condition:

____

Signature of Medical Authority: _______________________________ Date:: ____________________________