Fairfield Area School District

FACIAL COVERING/MASK EXCLUSION FORM

This form must be completed **BY A PHYSICIAN/MEDICAL PROVIDER** in its entirety prior to the student entering school without a mask. If a student arrives to school without proper documentation, student will be required to wear a mask or be sent home.

Name of student ______________________________ DOB__________ Grade ______

Medical condition/reason facial covering is being excluded ____________________

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If student is able to wear a facial covering for certain periods of time or instances during the day (such as in the hallway, on the bus, for 15 minutes each hour, etc) please list those specific guidelines here ______________________________

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Print Provider's Name, Title ____

Phone ______________________________ Fax ______________________________

Office ____

Provider's Signature ____________________________________ Date __________

Parent Authorization

By signing this form, I/we are consenting to contact between the school nurse and the physician on this form. Any medical condition requiring further information will be discussed privately and in accordance with HIPAA/FERPA guidelines. Information on this form will need to be renewed on an annual basis.

Primary Phone # ________________________ Secondary Phone # ____________________

Parent/Guardian Signature ______________________________________ Date __________

Please contact the School Health Office with any questions at 717-642-2013 or email ebaughk@fairfiel.k12.pa.us.