# Fairfield Area School District

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## FACIAL COVERING/MASK EXCLUSION FORM

Name of student _____ DOB_____ Grade ___

Medical condition/reason facial covering is being excluded _____

_____

_____

If student is able to wear a facial covering for certain periods of time or instances during the day (such as in the hallway, while unable to maintain social distancing indoors, for 15 minutes each hour, etc) please list those specific guidelines here _____

_____

_____

Print Physician's Name, Title, Office _____

Phone _____Fax _____

Provider's Signature _____ Date _____

## Parent Authorization

_____ By initialing, I acknowledge that I am not seeking the advice of my child's pediatrician.

_____ By initialing, I am choosing to go against the advice of the FASD, PA Department of Education, PA Department of Health, and CDC for a safe and healthy environment at school.

_____ By initialing, I understand that if my child is identified as a close contact exposure to a positive Covid case, my child will be required to wear a mask for 14 days while in school or I can choose to do learning at home for the exposure period.

Parent/Guardian Signature _____

Parent/Guardian Print Name_____Date _____

Primary Phone _____ Secondary Phone _____

Principal _____ School Nurse _____