THE SCHOOL DISTRICT OF PHILADELPHIA

Student Mask Coverings – Accommodation Request

The School District of Philadelphia recognizes that some students may have disabilities, medical conditions, or mental health conditions that prevent the student from safely or effectively wearing a mask. To receive an exemption from applicable mask requirements, this form must be completed in its entirety and emailed or dropped off to the IEP/504 accommodation team and/or school nurse. **Students with prior documentation on-file of a medical condition, mental health condition or disability that requires accommodation do not need to complete Part 2.**

Student Name:	Student's Grade:

Part 1: For completion by parent/guardian:

- I request that my child, _____, be exempt from mask requirements while at school based on the qualifying medical condition(s) reported by the medical professional below. I understand and agree to the following:
- I confirm that wearing a mask would either cause a medical condition or exacerbate an existing one, including a medical condition, a mental health condition or disability.
- I confirm that my child and I understand there may be an increased risk of exposure to COVID-19.
- I confirm that the school may take additional safety precautions such as encouraging my child's use of a face shield, virtual learning or providing at-home COVID testing.
- I confirm that I am expected to comply with all other COVID-19 mitigation strategies including keeping my child home for any sign of illness.

_____ _____

Parent/Guardian Signature Date

Part 2: For completion by Medical Professional (MD, DO, PA, or NP):

I certify that this student has a medical condition, mental health condition or disability that substantially limits a major life activity as described below AND that use of a mask may cause harm to the student.

Impairment type (check): Physical Medical Mental	List Impairments:	
List Contraindications of mask wearing & check option below:		
Student may wear mask as tolerated / frequent breaks	Student may not wear a mask	
Medical Professional Name (print):	Medical License #:	Phone #:

_____ _____

Signature of MD, DO, PA, or NP Date