CHARTIERS VALLEY SCHOOL DISTRICT
Mask Accommodation Request Form – Medical

By Order of the Acting Secretary of the Pennsylvania Department of Health dated August 31, 2021, each teacher, child/student, staff member or visitor working, attending or visiting a school must wear a face covering indoors, regardless of vaccine status. The Order provides that an individual may be exempted from the face covering requirements if wearing a face covering would either cause a medical condition, or exacerbate an existing one, including respiratory issues that impede breathing, a mental health condition or a disability, and that schools should provide reasonable accommodations for individuals who have a medical condition, mental health condition, or disability that makes it unreasonable for the person to maintain a face covering. The Order further provides that all alternatives to a face covering, including the use of a face shield, should be exhausted before an individual is exempted from the Order.

To request an exemption from the Order and accommodation, this form must be fully completed and submitted to your building principal along with any required documentation, if applicable.

Student Name:	Student Grade:
Student Building:	
Parent/Guardian Name:	Parent/Guardian Phone:
Parent/Guardian Signature:	Date:

To be Completed by Parent/Guardian

My child has a:

☐ **Disability** that prevents the child from wearing a mask. This determination is made by the School IEP or 504 Team.

If the student has a current IEP or 504 accommodation, no health care provider signature is required on this Form.

CVSD Special Education
Department Signature:_____ Date: _____

☐ **Medical Condition** that prevents the child from wearing a mask. **My child's health care provider has completed the Medical Certification form below providing information regarding my child's medical condition.**

Medical Certification – To be Completed by Health Care Provider

Health Care Provider Name:

Health Care Provider Phone Number:	Health Care Provider License (M.D./P.A., etc.):

Please answer all of the questions below, based on your treatment of the student and your familiarity with the student's medical history and/or condition.

1. Does the student have a physical or mental impairment that substantially limits a major life activity, including major bodily functions?

   _____ Yes. _____ No.

2. If yes, what is the impairment or nature of the impairment?

3. Does this impairment impact the student's ability to wear a mask? And if so, how?

4. Is the student able to wear a mask for any period of time?

   _____ Yes. _____ No.

5. If yes, how long?

6. Do you have any suggestions regarding possible accommodations the District may provide to the student, in order for the student to receive in-person school instruction? If so, what are they?

Heath Care Provider Signature:	Date: