Request for Face Covering Exemption – 2021/2022 School Year

Properly wearing a dual-layered cloth face covering or mask is one of the best tools available to reduce the spread of COVID-19. CMS requires that face coverings be worn by all students, teachers, staff, and visitors inside CMS schools and facilities. Face coverings are also required while traveling on buses or other school transportation vehicles. The use of face coverings outdoors is optional.

Unless fully vaccinated and symptom-free, students who are exempted from wearing a face covering will be required to quarantine (out of school for up to 14 days) if identified as a close contact in the school setting with someone who tests positive.

****New for the 2021-2022 School Year****

Exemptions from wearing a face covering due to medical, developmental, or behavioral reasons require certification by a medical provider. To obtain approval for an exemption, parents/guardians must submit this completed form to their students' school administrator. The student's healthcare provider must complete the applicable section of the form.

(This section to be completed by the parent/guardian)

Student Name: _____ **Grade:** ___ **School:** _____

As the parent/guardian of the above-named student, I affirm that my student has a developmental, behavioral, or medical condition that substantially interferes with the student's ability to wear a face covering indoors during school hours.

(Check if applicable) My student has on file ☐ Individualized Education Program (IEP) ☐ Section 504 Plan ☐ Health Plan

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____ **Date**: _____ / _____ / _____

(This section to be completed by the appropriate healthcare provider)

As a medical provider for the above-named student, I affirm that the student has a developmental, behavioral, or medical condition that substantially interferes with the student's ability to wear a face covering indoors during school hours, as indicated below:

- ❑ Medical
- ❑ Behavioral
- ❑ Developmental

Printed Name of Healthcare Provider: _____

Signature of Healthcare Provider: _____

Date: ____ / ____ / _____

Name and Address of Practice/Organization: _____

_____

Phone Number: (_____) _____ - _____