

# COVID-19 STUDENT MASK EXEMPTION REQUEST FORM



|                      |                          |
|----------------------|--------------------------|
| Student's Full Name: | Student's Date of Birth: |
|----------------------|--------------------------|

As the student's health care provider, I certify the following:

**Part 1:** The student has a (check all that apply):

- Medical condition     Mental health condition     Disability     Communication Disorder

Please describe/list:

**Part 2:** The student is a person who:

- Has a medical condition for whom wearing a mask could obstruct breathing. Please explain:
- Is unconscious. Please explain:
- Is incapacitated. Please explain:
- Is otherwise unable to remove a mask without assistance. Please explain:
- Is hearing impaired. Please explain:
- Is communicating with a person who is hearing impaired where the ability to see the mouth is essential for communication. Please explain:

**Part 3:** Does the student's condition permit them to wear a non-restrictive alternative such as a face shield with a drape on the bottom edge? Note, that CDPH Guidance requires students to wear a non-restrictive alternative as long as their condition permits it.

- Yes, the student can wear a face shield with a drape.
- Yes, the student has a communication disability and can wear a clear face covering or a cloth face covering with clear panel, or a face shield with a drape.
- Yes, the student can wear a non-restrictive alternative. Other alternative:
- No, the Student cannot wear an alternative. Please explain:

**Part 4:** Anticipated duration of exemption:

- This exemption is permanent.
- This exemption is temporary (temporary exemption ends on \_\_\_/\_\_\_/\_\_\_).

# COVID-19 STUDENT MASK EXEMPTION REQUEST FORM



|  |                    |
|--|--------------------|
| <b>Part 5:</b> I am a:<br><input type="checkbox"/> Physician<br><input type="checkbox"/> Nurse Practitioner<br><input type="checkbox"/> Other licensed medical professional practicing under the license of a physician. If so, include the name and license number of the doctor you practice under here: |                    |
| Name of Medical Provider (Print):  | Medical License #: |
| Signature of Medical Provider:   | Date:              |
| Phone Number:  | Address:           |

**Disclaimer:**

As the information contained herein is necessarily general, its application to a particular set of facts and circumstances may vary. For this reason, this document does not constitute legal advice. We recommend that you consult with your counsel prior to acting on the information contained herein.

**Copyright © 2021 Lozano Smith All rights reserved.**

No portion of this work may be copied, distributed, sold or used for any commercial advantage or private gain, nor any derivative work prepared therefrom, nor shall any sub-license be granted, without the express prior written permission of Lozano Smith through its Managing Partner. The Managing Partner of Lozano Smith hereby grants permission to any client of Lozano Smith to whom Lozano Smith provides a copy to use such copy intact and solely for the internal purposes of such client. By accepting this product, recipient agrees it shall not use the work except consistent with the terms of this limited license.