Midlothian School District 143

Physician Certification for Face Covering Exemption

Pursuant to guidance issued by the Illinois State Board of Education and the Illinois Department of Public Health, for the 2020-2021 school year, "all individuals in school buildings, including all public and nonpublic schools that serve students in prekindergarten through grade 12, must wear face coverings at all times unless they are younger than 2 years of age; have trouble breathing; or are unconscious, incapacitated, or otherwise unable to remove the cover without assistance." Part 3 – ISBE/IDPH Guidance.

For students who are unable to wear a face covering due to the exemptions above, please ask your child's physician to complete the form below and return it to the building Principal.

1. Student Information

School Name _____ Grade _____

Grade _____ Date of Birth _____

Parent or Guardian _____

Home Phone _____ Cell Phone _____

Parent/Guardian Work Number _____

Home Address _____

Home Email Address _____

Completed by: _____ Date _____

2. Physician Information (Completed by Physician)

Physicians Name (Print) _____

Physicians Specialty (area of practice) _____

Hospital Affiliation _____

Physician's Phone _____ Fax _____

Physician's Email _____

Physician's Signature _____ Date _____

3. Qualifying Student Exemption for Face Covering in School (completed by physician- please attach physician's orders)

Date of Most Recent Medical Examination _____

Describe medical condition(s) that precludes the student's ability to wear a face covering: _____

_____

_____

Please check any of the following that apply:

☐ Student has trouble breathing.

☐ Student is unconscious, incapacitated, or otherwise unable to remove the cover without assistance.

Specify any alternatives to a face covering that may be available to this student (e.g. face shield, etc.).

4. Other Information, If Applicable

5. Release of Information

I hereby grant my consent to Midlothian School District 143 to communicate and exchange any and all student record and medical information with the physician listed above in Section 2 of this form. The purpose for this disclosure is educational planning. If I do not grant this consent, the District will not exchange information with the physician, but I will not suffer any other consequences. This consent is valid for one calendar year from the date set forth below, and may be revoked at any time in writing.

6. Administrator Information (completed by District)

I _____ (print name) reviewed all sections of the Physician Certification, including information from the physician and consider the information to be complete and correct.

Administrator's Signature _____

Parent/Guardian Name (print) _____

Parent/Guardian Signature _____

Date _____