Quakertown Community School District

Universal Face Covering Order Exemption Request / Consent to Disclose Records

Date: _____ Name of Student: _____ Date of Birth: _____

School: _____

I am the parent or legal guardian of the above student, and I am requesting an exemption under Section 3B of the Order for my child from the universal requirement that all students wear masks at school. Section 3B states: 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. My child has the following medical condition, mental health condition or disability: _____. I have observed this condition or disability when: _____ _____.

I understand that the Quakertown Community School District must evaluate all available evidence to determine whether my child has a medical condition or disability that would entitle my child to the protections of Section 504 of the Rehabilitation Act of 1973. I further understand that I am not obligated to provide medical information concerning my child to support my request for a mask-wearing exemption. The absence of such information, however, could impair and possibly delay the ability of the school district to evaluate my exemption request.

Although not obligated to do so, but to assist in the evaluation of my child for a mask exemption, I have attached a medical certification from a licensed physician (M.D. or D.O.) that includes a clear diagnosis of the need for an exemption from the universal face covering order.

Although not obligated to do so, additionally, I authorize the Quakertown Community School District and _____ (certifying physician) to provide student records and medical information to each other related to the medical diagnosis and the request for an exemption from the universal face covering order.

I understand that I have the right to inspect and receive a copy of the said records. I also understand I have the right to revoke consent at any time. The permission is valid for the one calendar year from the date signed.

Name of Certifying Physician:	
Phone:	
Address:	

I am providing the foregoing information subject to penalty for making unsworn falsification to public officials, 18 Pa. Cons. Stat. § 4904. **I understand that my child must comply with the mandate until this exception request is approved.** I further understand that by not masking, my child may be at increased risk of contracting COVID19, and will be subject to a different close contact definition and quarantine requirements.

Parent/Guardian Name: _____

Signature of Parent/Guardian: _____ Date: _____

FOR SCHOOL DISTRICT USE ONLY:

Date Received: _____ Date Reviewed:_____ Date 504 Meeting Held: _____

Approved _____ Denied _____ Pending Additional Information Requested: _____