TELRA INSTITUTE

REQUEST FOR FACE COVERING EXEMPTION/FACE SHIELD AUTHORIZATION

A student in grades K-12 may be exempt from the requirement to wear a "face covering" at school if a "medical authority" certifies that the student has a medical condition, mental health condition, or disability that makes it unreasonable for the student to wear a face covering. A student who is not exempt from wearing a face covering may qualify to use a face shield as an alternative to a face covering if the student is unable to tolerate a face covering because of a developmental, behavioral , or medical condition.

- "Face covering" means a paper or disposable mask, cloth face mask, medical-grade mask, medical grade respirator, scarf, bandanna, neck gaiter, or religious face covering that covers the nose and mouth completely in accordance with CDC guidance.

- "Face shield" means a clear plastic barrier that covers the face, extends below the chin, and wraps around the sides of the face to the ears. A face shield may not have an exposed gap between the forehead and the shield's headpiece.

- "Medical authority" means a medical doctor, clinical psychologist, physician assistant, or nurse practitioner who has seen or treated the student.

If you believe that your child is exempt from wearing a "face covering," you must sign this form and have a "medical authority" sign and complete this form.

If your child is not exempt from wearing a face covering but you believe your child cannot tolerate a face covering because of a developmental, behavioral, or medical condition, you must sign this form and have a "medical authority" sign and complete this form.

This form must be emailed to frontdesk@telra.org. School administration will make the final determination of whether the student qualifies for an exemption or for the use of a face shield instead of a face covering.

TO BE COMPLETED BY PARENT/GUARDIAN

Student name:_____

Address:_____

Date of Birth:_____

I certify that the information on this form is true and accurate to the best of my knowledge.

Parent signature: _____ Date: _____

Please complete additional information on the back side of this form

TO BE COMPLETED BY MEDICAL AUTHORITY

Print Name: _____ Clinic Phone: _____

Name of Clinic: _____

Clinic Address: _____

Clinic Phone: _____

Based on personal knowledge from examining, treating, or reviewing the medical records of the student who is identified above, I certify that the following is true and accurate (check those that apply and identify condition):

☐ The student has the following medical condition, mental health condition, or disability that makes it unreasonable for the student to wear a face covering at school:

_____

☐ The student is unable to tolerate a face covering and should be permitted to use a face shield at school because of the following developmental, behavioral, or medical condition:

_____

Signature of Medical Authority: _____

Date: _____