UNION LOCAL SCHOOL DISTRICT

Request for Face Covering Accommodation

This form, along with the physician verification form, must be completed in its entirety by parents/guardians who are requesting an accommodation to the District's Face Covering Protocol. The completed forms should be turned into the assistant principal for student services who will schedule a 504 or IEP meeting to review and consider the request and, if approved, determine a plan for maintaining the health and safety of the student and all other individuals in the school.
The District may verify all information provided by the student's parent/guardian and/or the student's physician through an independent review by a licensed medical provider of the District's choice.

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

Name of Parent/Guardian_____ **Phone Number:** _____

Email Address: _____

My student has a current: (Please check all that apply)

☐ **IEP** ☐ **504 Plan** ☐ **Health Plan** ☐ **New Medical Condition**

Please identify the reason for the request for the accommodation

Please identify the accommodation you are requesting

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I authorize the District and the Physician listed above to mutually exchange information, including conversations, concerning my student's medical condition and the impact of the medical condition on my student's compliance with the District's face covering protocol. This authorization is valid for one calendar year unless otherwise revoked in writing. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I understand that failing to authorize disclosure of information may impact the District's ability to grant my request for reasonable accommodations. I recognize that health records, once received by the school district, may not be protected by the HIPAA Privacy Rule, but will become education records protected by the Family Educational Rights and Privacy Act and the Illinois School Student Records Act. I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain a free education.

Parent Name: _____ **Date:** _____

Parent Signature: _____

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Physician Verification of Medical Exemption for Face Covering Must be completed by a licensed physician (MD/O, NP, PA)

Identify the medical condition that prevents the individual from wearing the required face covering:	
Explain, with specificity, the nature of the individual's medical condition and why it is medically contraindicated for the individual to comply with the face covering protocol attached	
Please indicate the specific detrimental effect of the face covering requirement	
Are there any accommodations that would address the individual's needs and enable compliance with the face covering protocol?	
If there are no accommodations that would allow compliance with the face covering protocol, please identify precautions that can be taken to offer the same or similar protection to others?	

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If face coverings cannot be required under any circumstances, please complete the following questions:

Is the individual able to be around others who wear face coverings or other protective equipment?	YES	NO

If no, please explain:

Any additional recommendations or information we need to protect the health and safety of the student or others?

I hereby certify that this student has a medical condition that requires accommodations to or exemption from to the face covering protocol as stated above.

Name of Physician: _____

Physician Signature: _____ **Date:**_____

Physician's Contact Information:

Office Number:_____ **Fax Number:**_____

The District reserves the right to seek an independent medical assessment of students to verify the information provided on this form.

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