PLEASANT VALLEY SCHOOL DISTRICT

PHYSICIAN CERTIFICATION FOR REQUEST FOR

EXEMPTION TO MASK MANDATE

Instructions: This Form must be completed fully, including the certification, by the Student's/Employee's medical doctor and submitted to the District in support of any request for exemption to the District's mask mandate based upon a disability or medical condition. Please note that a letter from the Student's/Employee's medical provider will not be accepted in lieu of this Form.

Please be sure to sign the certification on the next page. All completed forms are to be returned to the Superintendent's Office.

Student/Employee Information

Please check one: **Student** ☐ **Employee** ☐ **Employee Position:** _____

Name: _____

Student Parent/Guardian: _____

Address: _____

Date of Birth: _____

School Building: _____

1. I certify the above-named person is currently under my care and has the following diagnosis or condition (please state with specificity and how long):

_____

_____

2. In your professional judgement, as a result of the aforementioned diagnosis or condition is this person unable to wear a mask safely, as outlined by the CDC or subject to an exemption to August 31, 2021 Order of the Acting Secretary of the Pennsylvania Department of Health Directing Face Coverings in School Entities?

Yes ____ **No** ____

3. To your knowledge, did the person wear a mask in school during 2020-21 school as a student or employee of the district?

Yes ____ **No** ____

4. Explanation of medical/mental health condition as it would impact mask wearing:

_____

_____

_____

5. In lieu of wearing a mask which reasonable accommodations would be appropriate:
   - _____ Mask breaks: recommended frequency and duration _____
   - _____ Use of a clear face shield
   - _____ Strategic plan to increase tolerance for mask wearing
   - _____ Other: _____

Certification

I certify that the information provided above is truthful and that, in my professional medical opinion, (patient name) _____ has the stated medical condition and limitations, and requires the recommended accommodation(s). I understand that the submission of information without a legitimate medical basis is a breach of my ethical duties as a licensed health care provider, and may be reported to licensing authorities for possible disciplinary proceedings.

_____ _____

Signature of Health Care Provider Date

Health Care Provider's Name: _____

Area of Specialization: _____

License Number: _____

Address: _____

_____

Telephone Number: _____

Fax Number: _____