CANTON AREA SCHOOL DISTRICT
REQUEST FOR EXEMPTION TO MASK MANDATE

Instructions: This Form must be completed fully in support of any request for an exemption to the District's mask mandate ordered by the Pennsylvania Department of Health. Please note that forms, letters, or other correspondence submitted in lieu of this Form will not be accepted.

Please note that your child will be required to comply with the District's mask mandate until you have received an exemption in writing from the District.

Student Information

Name of Student: _____

Parent/Guardian: _____

Address: _____

Date of Birth: _____

School: _____

Request for Exemption to Mask Mandate

Reason for request for exemption to mask mandate:

Did your child wear a mask last year: Yes____ No _____

If you are requesting an exemption based on a disability or medical need, you must also submit a completed Physician Certification and executed Release. The District will not consider this request without these documents.

I certify that the information provided above is accurate and complete. In addition, I affirm that my child will comply with the District's mask mandate until I receive notice in writing that my child has been exempt. I further affirm that to the extent an exemption is granted; my child will comply with any and all limitations included within the exemption.

Signature of Parent/Guardian Date

RELEASE

I hereby authorize Canton Area School District to release/obtain my child's educational/health records and information to/from the medical provider who completed the Physician Certification.

I understand that the terms of this Authorization are governed by the Health Insurance Portability and Accountability Act of 1996, and it's implementing regulations ("HIPAA"). I understand thatI have the right to revoke this Authorization, at any time prior to the Canton Area School District's compliance with the request set forth herein, provided that the revocation is in writing. I further understand that additional information relating to the exceptions to the right to revoke and a description of how I may revoke this Authorization is set forth in the Canton Area School District's Notice of Privacy Practices. I understand that any revocation must include my name, address, telephone number, date of this Authorization and my signature and that I should send it to:

Mrs. Amy Repard

545 East Main Street

Canton, PA 17724

I understand that I am not required to sign this authorization and that the Canton Area School District may not condition treatment on my execution of this Authorization.

I understand that the information used or disclosed pursuant to this Authorization may be subject to redisclosure by the Recipient listed above and, in that case, will no longer be protected by HIPAA.

This Authorization expires one year after the signed Date of Authorization, or parent provides written request revoking authorization; whichever comes first.

Signature of Parent/Guardian

Date of Authorization

CANTON AREA 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 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 medical provider will not be accepted in lieu of this Form.

Student Information

Name of Student: _____

Parent/Guardian: _____

Address: _____

Date of Birth: _____

School: _____

Medical Information

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

2. In your professional judgment, because of the aforementioned diagnosis or condition is the student unable to wear a mask or unable to wear a mask safely, as outlined by the CDCor 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 student wear a mask in school during the 2020-21 school year?

   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: _____