ALBERT GALLATIN AREA SCHOOL DISTRICT
CERTIFICATION OF HEALTH CARE PRACTITIONER
FACE COVERING EXEMPTION FORM

Student Name_____________________________

To Health Care Practitioner:

The Parent/Guardian of the Albert Gallatin Area School District Student referenced above has requested a medical exemption from wearing a face covering while attending school.

As the Student's Health Care Provider, you are asked to provide the following information:

Health Care Practitioner's name: (Print)________________________________________

Health Care Practitioner's Title/ Certification/Licensure:___________________________

Health Care Practitioner's business address:_____________________________________

Type of practice/medical specialty:_________________________________________

Telephone: (       )______________(Fax)___________________

Email address:________________________________________

1. Based on your professional knowledge, experience, and knowledge of this Student, does the Student currently suffer from a medical condition, mental health condition or a disability that would be exacerbated by being required to wear a face covering (other than a face shield) indoors at school?

   Yes:_______   No:__________

   If yes, please explain_______________________________________________________

1.A. If yes, would this medical condition, mental health condition or disability preclude the Student from safely wearing a face shield indoors in school?

   Yes:_________   No:__________
2. Based on your professional knowledge, experience, and knowledge of this Student, would a requirement that the Student wear a face covering (other than a face shield) indoors at school cause the Student to develop a medical condition, mental health condition or a disability?

   Yes_____________ No_______________

   If yes, please explain____________________________________________________________

2.A. If yes, would this also preclude the Student from safely wearing a face shield indoors in school?

   Yes_____________ No_______________

3. Based on your professional knowledge, experience, and knowledge of this Student, is the Student hearing-impaired or suffering from another disability where the ability to have his/her mouth seen, is essential for communication, such that being required to wear a face covering (other than a face shield) indoors at school would exacerbate the Student's hearing-impairment or other disability?

   Yes___________ No_______________

   If yes, please explain___________________________________

3.A. If yes, would this preclude the Student from safely wearing a face shield indoors in school?

   Yes_______ No_______

4. Please provide any additional information which, in your professional opinion, is relevant to these issues.

Signature of Health Care Provider:  _________________________________

Date: ____________________