Zion Elementary District 6

PHYSICIAN CERTIFICATION FOR FACE COVERING EXEMPTION

Pursuant to Governor Pritzker's August 4, 2021, Executive Order Number 18 (COVID-19 Executive Order No. 85), all public and nonpublic schools in Illinois serving pre-kindergarten through 12th grade students must follow the joint guidance issued by the Illinois State Board of Education (ISBE) and the Illinois Department of Public Health (IDPH) and require "the indoor use of face coverings by students, staff, and visitors who are over age two and able to medically tolerate a face covering, regardless of vaccination status." Executive Order Number 18: https://www.illinois.gov/government/executive-orders/executive-order.executive-order-number-18.2021.html.

Pursuant to the IDPH/ISBE August 2, 2021, joint FAQ guidance, schools may make limited exceptions to this requirement for students "who cannot wear a mask or cannot safely wear a mask because of a disability as defined by the Americans with Disabilities Act (ADA) (42 U.S.C. 12101 *et seq*.)." IDPH/ISBE FAQ: https://www.isbe.net/Documents/ISBE-School-FAQs-20210802.pdf.

For students who are unable to wear a face covering due to the exemption above, please ask your child's medical provider to complete the relevant portions of this form and return it to your school's nurse.

1. **STUDENT INFORMATION**

   Student's Name_____School Name_____

   Date _____ Date of Birth_____

   Completed by:_____

   Grade_____ Parent or Guardian _____

   Home Phone Number _____ Cell Number _____

   Home Address_____

   Parent/Guardian Work Number_____Home E-mail_____

2. **PHYSICIAN INFORMATION** (completed by medical provider)

   Physician's Name (Print)_____Physician's License Number_____

   Physician's Specialty (area of practice)_____

   Phone_____Fax_____Physician's E-mail_____

   Physician's Signature_____Date Signed_____

3. **DETERMINATION STUDENT CANNOT MEDICALLY TOLERATE A FACE COVERING** (completed by medical provider – please attach physician's orders)

   Date of Most Recent Medical Examination_____

   Describe disability/medical condition(s) that precludes the student's ability to wear a face covering: _____
   _____

   Specify any alternatives to a face covering that may be available to this student (*e.g.*, face shield, intermittent use of face covering with scheduled breaks, etc.)._____
   _____
   _____

4. **OTHER INFORMATION, IF APPLICABLE**

   _____
   _____
   _____

5. **RELEASE OF INFORMATION**

   I hereby grant my consent Zion District 6 to communicate and exchange any and all student record and medical information with the medical provider listed above in Section 2 of this form. The purpose for this disclosure is educational planning. If I do not grant this consent, the District will not exchange information with the medical provider, but I will not suffer any other consequences. I understand I have the right to inspect and copy the information to be disclosed pursuant to this consent. This consent is valid for one calendar year from the date set forth below and may be revoked at any time in writing.

6. **SCHOOL NURSE/ADMINISTRATOR INFORMATION** (completed by District personnel)

   I, _____(print name), reviewed all sections of the Physician Certification, including any attached orders.

   School Nurse/Administrator Signature _____

SIGNATURE

PARENT/GUARDIAN NAME: _____

PARENT/GUARDIAN SIGNATURE: _____

DATE: _____