INTERBORO SCHOOL DISTRICT
900 Washington Avenue
Prospect Park, PA 19076

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 School Nurse who will review with the building administrator 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.

Student Name:		Date of Birth:	
Name of Parent/ Guardian		Parent/Guardian Phone Number:	
Parent/Guardian Email Address:			
My student has a current:	• IEP • 504 Plan	• Health Plan • New medical condition	

Please identify the accommodation you are requesting:

Please identify the reason for the request for the accommodation:

I authorize the District and the Physician listed below 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 failure to authorize the 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. 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: _____

Parent Signature: _____

Date: _____

Face Covering Protocol

To prevent the spread of COVID-19, Face coverings will be required for all district staff members, students, and visitors over the age of 2 who are present in any district building, utilizing school bus or other district vehicles, and when outside on school grounds, when social distancing cannot be maintained. The primary purpose of face coverings is to prevent an individual from potentially exposing or infecting others with the virus.

Face coverings are masks or other cloth face coverings which cover an individual's nose and mouth. They should be fitted to the face but permit breathing without restriction.

Students

Appropriate face coverings must be worn by students based upon the current metrics, in school buildings, on school buses, at school activities, and when outside on school grounds, when social distancing cannot be maintained.

Students will be responsible for providing their own face covering that is aligned to CDC guidelines.

- The mouth and nose are fully covered.
- There are multiple layers of fabric that can sustain daily washing and drying.
- The covering fits snugly against the sides of the face so there are no gaps.
- Allows you to breathe without difficulty.
- Can be tied or otherwise secured to prevent slipping.

For students without a face covering or unable to find one aligned to CDC guidelines, a face covering will be provided. Face coverings may be removed while actively eating and drinking as long as students are stationary (seated at desk or table) and are maintaining appropriate social distance (3ft.)

If a student consistently refuses to wear a mask appropriately, the building administration will work with the student and family however, if the issue persists, the administrator may have to implement additional measures that include the use of the student code of conduct and/or an alternate instructional model.

Families may seek an accommodation or modification to the face-covering requirement if their student:

- Has a medical contraindication, e.g., difficulty breathing at rest, and/or
- is developmentally (physically or intellectually) disabled, such that they are unable to remove a mask if needed
- May not have exhalation valve or vent.

Please have your physician complete p. 3 and p. 4. and return the form to Attn: School Nurse.

Physician Verification of Medical Exemption for Face Covering			
Only those licensed professionals authorized to conduct pediatric health examinations consistent with 105 ILCS 5/27-8.1(2), including physicians licensed to practice medicine in all branches of medicine, licensed advanced practice registered nurses, and licensed physician assistants, may provide a medical note indicating that a student is medically unable to tolerate a face-covering.			
Student Name:		Date of Birth	
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?			
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:			
Is the individual able to be around others who are also unable to wear face coverings if social distancing is maintained?	Yes	No	
If no, please explain:			
Are there 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 or exemption from the face-covering protocol, as stated above.	
Name of Physician:	
Physician Signature:	
Date:	
Physician Contact information, including phone number:	