BUUSD Student Face Covering Accommodation Documentation

It is the expectation of the BUUSD that all staff and students wear face coverings in accordance with United States Centers for Disease Control and Prevention and Vermont Agency of Education guidance. This form documents accommodations or exemptions to that expectation.

Student Name: ______________________________ Date of Birth: _____________

Student's Physician: ___________________________________

Accommodation Description	
Reason for request	
Documentation (ie, Meeting minutes, Doctor's note)	

I authorize the District and the Physician listed above 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 failing to authorize 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: _______________________________ Date:________________

Parent Signature or Authorization: _________________________________

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Approved by Nurse: ___________________________________ Date: ___________

Printed Name: ____

Approved by Administrator: ____________________________ Date: ___________

Printed Name: ____
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