Palos School District 118

PHYSICIAN CERTIFICATION FOR FACE COVERING ACCOMMODATION

Pursuant to guidance issued by the Illinois State Board of Education and the Illinois Department of Public Health, for the 2020-2021 school year, "all individuals in school buildings, including all public and nonpublic schools that serve students in prekindergarten through grade 12, must wear face coverings at all times unless they are younger than 2 years of age; have trouble breathing; or are unconscious, incapacitated, or otherwise unable to remove the cover without assistance." Part 3 – ISBE/IDPH Guidance.

Accommodations for inability to wear face covering may include additional face mask breaks throughout the school day or remote learning. The school district will not allow face shields in lieu of face masks as an accommodation. IDPH does not recognize face shields as an acceptable alternative to a face mask.

For students who are unable to wear a face covering due to the above, please ask your child's physician to complete the form below and return it to: Erin Deval, Director of Student Services at edeval@palos118.org or drop off at District Office at 8800 West 119th Street.

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 the physician)**

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

   Physician's Specialty (area of practice)_____

   Phone_____Fax_____Physician's E-mail_____

   Hospital(s) Affiliation(s)_____

   Physician's Signature_____Date Signed_____

3. **QUALIFYING STUDENT ACCOMMODATION FOR FACE COVERING IN SCHOOL (completed by physician- please attach physician's orders)**

   Date of Most Recent Medical Examination_____

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

_____

_____

_____

Please check if any of the following apply:

□ Student has trouble breathing.

□ Student is unconscious, incapacitated, or otherwise unable to remove the cover without assistance.

4. **OTHER INFORMATION, IF APPLICABLE**

_____

_____

_____

5. **RELEASE OF INFORMATION**

I hereby grant my consent to Palos School District 118 to communicate and exchange any and all student record and medical information with the physician 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 physician, but I will not suffer any other consequences. 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)**

I _____(print name) reviewed all sections of the Physician Certification, including letter from the physician and consider the information to be complete and correct.

School Nurse/Administrator signature _____

SIGNATURE

PARENT/GUARDIAN NAME: _____

PARENT/GUARDIAN SIGNATURE:_____

DATE: _____