



FACE COVERING EXEMPTION FORM

SMPSB Student

SMPSB Employee

NOTIFICATION OF FACE COVERING EXEMPTION

This letter is to advise school officials that due to medical contraindications

_____ is exempt from wearing a face covering.

(Please Print)

Signature: _____

(Parent if student)

Date: _____

By signing this form and not wearing a proper face covering, I acknowledge that I am at an increased risk of contracting COVID-19

Physician/Provider Name (Print): _____

Physician/Provider Contact Number: _____

I have examined the individual named above and determined that due to severe medical issues the individual is unable to fully function wearing a face covering. Based on my medical examination and my medical experience, I request that the named individual be exempt from the Governor's mask mandate.

Physician/Provider Signature: _____

Date: _____