Clear Form

MIAMI-DADE COUNTY PUBLIC SCHOOLS

Student Face Covering Medical Opt-Out Request Form

The Centers for Disease Control and Prevention (CDC) recommends the use of face coverings combined with social distancing to minimize the transmission of COVID-19.

STUDENT INFORMATION

Student Name:					
School Name:					
Student ID		Date of Birth (D.O.B.)		Grade:	
Parent/Guardian's Name:					
Parent/Guardian's Signature:					
Contact Number:		Email Address:			

Does your student have?: IEP ☐ Eligibility: _____ or Section 504 Plan ☐ Impairment: _____

Please submit the following certification from a Florida licensed Physician that includes a description of the reason for the request based upon medical reasons including valid clinical reasoning or evidence, demonstrating the need for the request and any supporting documentation to your child's school.

Request To be completed by Florida licensed Physician

Diagnosis of medical condition:		Date of Diagnosis:	
Please explain how the child's diagnosis prevents them from wearing a face covering/mask:			
Can the child wear a face covering/mask for a reduced amount of time? Please explain.			
Explain what other measures are recommended to mitigate the potential spread of COVID-19 by the student when no facial covering is worn:			

I attest that the above-mentioned student has medical limitations to the use of a facial covering/mask, as set forth above.

_____ Signature

_____ Title

_____ Florida licensed Physician's Name (Print/Stamp)

_____ Address

_____ Phone

_____ Email

PLEASE SUBMIT COMPLETED FORM TO SCHOOL PRINCIPAL

Date received by school:

Name:

Signature: