INDIAN PRAIRIE
SCHOOL DISTRICT 204

CERTIFICATION OF MEDICAL CONTRAINDICATION
USE OF A FACE COVERING

As a result of the COVID-19 pandemic, Illinois is currently operating under a five-phase plan referred to as *Restore Illinois*. Under Phase 4 of *Restore Illinois*, Illinois schools are permitted to return to in-person instruction so long as they adhere to health and safety guidance from the Illinois Department of Public Health (IDPH). To ensure the health and safety of students, staff, and the school community, students are expected to cooperate with all IDPH safety protocols at school and school-related activities, including the use of face coverings. A person may be exempted from using a face covering if there is a *bona fide* medical contraindication to its use. If you believe that your student has a medical condition that makes wearing a face covering contraindicated, please have the student's physician complete this form and return it to your child's school health office prior to the first day of school.

STUDENT INFORMATION:

Name of Student: _____ ID #: _____ DOB: _____

Name of Parent(s): _____

Parent(s)' Address: _____ Phone: _____

TO BE COMPLETED BY PHYSICIAN:

Medical Condition Diagnosis: _____

How long have you been seeing the student for this condition? _____

Does this condition preclude the safe use of a **face mask**? □ Yes □ No

If yes, please explain: _____

_____

Can the student wear a face mask for any period of time less than a full school day? □ Yes □ No

If yes, please describe the time limitations and provide any recommendations on the amount of time and frequency that the student can safely wear a face mask: _____

_____

Does the student have a medical contraindication to wearing a **face shield**: □ Yes □ No

If yes, please explain: _____

_____

Please describe how the condition affects the student's ability to wear a face shield: _____

_____

Can the student wear a face shield for any period of time less than a full school day? □ Yes □ No

If yes, please describe the limitations and provide any recommendations on the amount of time and frequency that the student can safely wear a face shield: _____

CERTIFICATION: I certify that this student is under my care and treatment for the aforementioned medical condition and that the responses I have provided above are accurate and medically supported.

Physician's Name (print) _____ Phone: _____

Signature: _____ Date _____

7-31-2020