Student Mask Medical Exemption Form

This form must be completed and signed by a licensed Florida medical doctor, a licensed osteopathic physician, or a licensed advanced registered nurse practitioner.

From City of Cape Coral Charter School Authority Governing Board Meeting Mask Policy 8/27/21:

The board passed a temporary mask mandate for all students and staff to reduce the spread of COVID-19 during the current surge initiated by the aggressive Delta variant. This surge is causing the positivity rate in students to increase at an alarming rate. We encourage parents/guardians to use this exemption only to the extent needed to accommodate their child so that we can keep other students and our staff safe.

Subject to the exceptions below, all individuals including students, employees, visitors, and vendors must wear a face mask that covers both the nose and mouth at all times while inside any campus building or bus.

A face covering shall not be required for persons who present school officials with this waiver from a licensed MD, OD or ARNP that the person has been diagnosed with a medical or physical contraindication that prevents the person from being able to safely wear a face covering.

Student name (print) _____

Last First

Student School: _____ Grade: _____

I hereby request that my child be released from the COVID -19 Emergency Mask Policy requirement for the 2021-2022 school year due to the reason selected below:

☐ My child cannot wear a mask ☐ My child cannot wear a face shield

I understand for everyone's safety, exemption from a face covering may result in additional health room visits, strategic social distancing, additional PPE and/or other safety protocols as necessary.

FOR LICENSED HEALTH CARE PROVIDER ONLY

I certify that _____ cannot wear____ a mask____ face shield ____ or both due

First and Last Name

to a medical or physical contraindication. Health Care Provider Stamp (below)

Health Care Provider License No. _____

Health Care Provide Phone No. _____

_____ _____ _____

Licensed Health Care Provider Name (Print) Licensed Health Care Provider Signature Date