TCA Mask Exemption Health Care Plan

Name____Birthdate_______________Grade__________
Teacher_____________________________________School________________Date__________
Physician____________________________________Phone_________________________________
Parent______________________________________Phone(s)________________________________

Health condition or diagnosis____

This section to be completed by a licensed medical provider with prescriptive authority (MD, DO, PA, or NP):

I certify that the individual identified above should be granted a **full or partial** (circle one) exemption from the face covering requirement due to the following medical or mental health diagnosis or developmental or intellectual disability. Please provide diagnosis or brief statement of impact: ____
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Students, teachers, staff, and visitors will be expected to wear a face covering while entering and exiting the building as well as while transitioning in high traffic or common areas such as hallways, restrooms, main offices, and while participating in fire drills, etc. Can this individual safely wear a face covering during these limited timeframes?: **Yes or No** If no, please include a brief explanation:____
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Students with mask exemptions are expected to wear a transparent face shield during these limited times or activities as a reasonable accommodation? Is this student able to wear a transparent face shield? **Yes or No** If no, please include a brief explanation:
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Students who display COVID-like symptoms at school will be sent home. While awaiting pick-up students will be masked in the isolation room. Is this student able to tolerate a mask while displaying COVID-like symptoms awaiting pick up **Yes or No?**

I give my permission for the school staff to contact the prescribing physician regarding this plan and the information on this Health Care Plan to be shared with adults in the school setting that will be working with my child on a need-to-know basis. If the action plan includes a mask/face covering exemption for a medical condition, the undersigned parent or guardian agrees to release The Classical Academy and its personnel from any legal claim which he, she or their child may now have or may hereafter have arising from medical consequences of not wearing a face covering while on school grounds and/or participating in school sponsored activities.

Parent______________________________________Date_________________

Signature of Health Care Provider with Prescriptive Authority: _________________________Date______

School Nurse__________________________________Date_