MASK QUESTIONNAIRE

PINE HILL SCHOOLS

Child's name:_____ Date of birth_____

Has your child: (circle one)

Used tobacco in the last 12 months?	Yes	No
Had an allergic reaction that interfered with breathing?	Yes	No
Had chest or heart surgery?	Yes	No
Tested positive for COVID?	Yes	No

Does your child:

Have asthma that needs daily medication?	Yes	No
Have diabetes?	Yes	No
Get short of breath with easy exercise?	Yes	No
React strongly to sensations? (Example: autism),	Yes	No
or would your child be unable to remove a mask?	Yes	No

Parent name:_____Today's date:_____

Please return this form to the Pine Hill Clinic ASAP.

Child's name:_____Date of birth_____

To be completed by healthcare provider:

Approved for mask use:

Approved with the following restrictions:

Child should not wear mask: (Note: child will not be allowed on school bus, and must keep 6 feet of distance from other students at all times)

Allowed activities:

Child needs to come in to the clinic for exam (call for appointment):

Provider:_____Date_____