

ROCKY HILL PUBLIC SCHOOLS
Face Covering Medical/Health Exemption Form

COVID-19 is a highly contagious virus that spreads by respiratory droplets released when individuals talk, cough or sneeze. Many individuals infected with COVID-19 are asymptomatic and contagious. Federal and state public health agencies, including the United States Centers for Disease Control and Prevention (CDC), recommend that individuals wear a face covering to limit the spread of COVID-19.

The Connecticut State Department of Education and Rocky Hill Public Schools require ALL students, beginning in preschool (ages three and over), to wear face coverings during the school day. Any student seeking a medical exemption to the face covering requirement must have the student's treating physician complete the below Medical/Health Exemption Form. As noted below, Rocky Hill Public Schools will consult with the student's treating physician to determine what reasonable accommodations, if any, would allow the student to wear a face covering during the school day. In light of the significant public health and safety requirements, the Rocky Hill Public Schools require that any request for medical exemption be completed and submitted to: Mark F. Zito, Ed.D., Superintendent of Schools, 761 Old Main St., Rocky Hill, CT, 06067; Phone: 860-258-7701; Fax: 860-258-7710.

Students submitting requests for medical exemption are subject to COVID-19 containment strategies pending the completion of the exemption review process. COVID-19 containment strategies may include assignment to home-based remote learning to mitigate the possibility of infection to the student or others in the physical school building.

Name of Child: _____ Date of Birth: _____
Address of Child: _____
Name of Parent(s)/Guardian(s): _____
Address of Parent(s)/Guardian(s): _____
(if different from child)

Contact Information for Treating Physician

Name: _____
Address: _____
Phone: _____ Fax: _____ Email: _____

THE ROCKY HILL PUBLIC SCHOOLS RESERVES THE RIGHT TO DENY MASK EXEMPTION REQUESTS WITHOUT SUFFICIENT INFORMATION TO DETERMINE THE HEALTH-RELATED NECESSITY OF SUCH REQUEST.

I HEREBY CONSENT TO SCHOOL OFFICIALS OF THE ROCKY HILL PUBLIC SCHOOLS CONSULTING WITH THE ABOVE-NAMED TREATING PHYSICIAN IN CONNECTION WITH THE REQUEST FOR A MEDICAL EXEMPTION FROM WEARING A FACE COVERING DURING THE COVID-19 PANDEMIC. I UNDERSTAND THAT MY CHILD'S TREATING PHYSICIAN IS AUTHORIZED TO EXCHANGE HEALTH/MEDICAL AND EDUCATIONAL INFORMATION RELATED TO THE FACE COVERING MEDICAL EXEMPTION REQUEST SUBMITTED ON BEHALF OF MY CHILD, _____ (Name of Student), WITH THE ROCKY HILL PUBLIC SCHOOLS. I UNDERSTAND THAT THE PURPOSE OF THE EXCHANGE OF SUCH INFORMATION IS TO DETERMINE WHETHER A MEDICAL EXEMPTION IS NECESSARY AND/OR WHETHER THERE ARE ANY REASONALBE ACCOMMODATIONS THAT SHOULD BE CONSIDERED IN CONNECTION WITH THE FACE COVERING EXEMPTION REQUEST. I UNDERSTAND THAT THIS AUTHORIZAITON WILL EXPIRE ON JUNE 20, 2021, UNLESS I REVODE THIS AUTHORIZATION AT AN EARLIER TIME BY SUBMITTING WRITTEN NOTICE OF THE WITHDRAWAL OF CONSENT. I ACKNOWLEDGE THAT HEALTH/MEICAL RECORDS, ONCE SHARED WITH THE ROCKY HILL PUBLIC SCHOOLS, WILL BE EDUCATION RECORDS UNDER FEERAL EDUCATION RECORD LAWS (FERPA) AND MAY NOT BE PROTECTED BY THE HIPAA PRIVACY RULE. I ALSO UNDERSTAND THAT REFUSAL TO CONSENT TO THE EXCHANGE OF INFORMATION DESCRIBED ABOVE WILL NOT AFFECT ACCESS TO HEALTHCARE.

Parent/Guardian Name (Please Print)

Date

Parent/Guardian Signature

The section below must be completed by the student's treating physician to verify a health or medical reason that prohibits the student from wearing a face covering in the school building and/or on school grounds or to identify possible accommodations for the student to wear a face covering within the school building or on school grounds. Upon completion, this form must be provided by the treating physician directly to the Rocky Hill Public Schools, care of: Mark F. Zito, Ed.D., Superintendent of Schools, 761 Old Main St., Rocky Hill, CT, 06067; Phone: 860-258-7701; Fax: 860-258-7710

The treating physician MUST consult with the school nurse prior to completing this form.

Medical Verification

Name of School Nurse: _____ Date Contacted: _____

Yes No

- I have consulted with the school nurse regarding the student's ability to wear a face covering due to a verified medical or health reason.

- After consultation with the school nurse, I have determined that reasonable accommodations would permit the student to wear a face covering for parts or all of the school day.

If yes, to the above questions:

I have determined that the following reasonable accommodations would permit the student to wear a face covering during the school day (examples include, without limitation, face covering breaks as specific intervals, use of face shield when a face covering is contraindicated, use of bandana or looser fitting face covering):

- After consultation with the school nurse, I have determined that the student cannot wear a face covering during the entire school day due to a verified medical or health reason.

The student has been diagnosed with the following medical condition(s) that prevent the student from wearing a face covering at all times during the school day:

***Documentation supporting the above diagnosis MUST be submitted to the Rocky Hill Public Schools along with this Medical Verification Form.**

By signing below, I verify that the above information is accurate to the best of my professional knowledge.

Signature of Treating Physician

Date

Print Name of Treating Physician

CT License No.