



UNION SCHOOL DISTRICT

"Home of the Golden Knights and Damsels"

Universal Face Covering Order Exemption Request / Consent to Disclose Records

Date: _____ Name of Student: _____ Date of Birth: _____

I am the parent or legal guardian of the above student, and I am requesting an exemption for my child from the universal requirement that all students wear masks at school. My child has the following medical condition or disability:

Medical Condition/Disability: _____

I have observed this condition or disability when: _____

I understand that Union School District must evaluate all available evidence to determine whether my child has a medical condition or disability that would entitle my child to the protections of Section 504 of the Rehabilitation Act of 1973. I further understand that I am being requested to provide medical information concerning my child to support my request for a mask-wearing exemption. My physician (M.D. or D.O.) attests to the following:

Medical Condition/Disability: _____

Major life activity that medical condition/disability substantially limits: _____

I authorize Union School District and _____ (certifying physician) to provide student records and medical information to each other related to the medical diagnosis and the request for an exemption from the universal face covering order. **I have attached a medical certification from a licensed physician (M.D. or D.O.) that includes the mental and/or physical impairment, and the area(s) that the impairment substantially limits.**

I understand I have the right to revoke consent at any time. **The permission is valid for the one calendar year from the date signed.**

Name of Certifying Physician: _____

Signature of Certifying Physician: _____

Physician's Address: _____

I am providing the foregoing information subject to penalty for making unsworn falsification to public officials, 18 Pa. Cons. Stat. § 4904.

Parent/Guardian Name: _____

Signature of Parent/Guardian: _____

Date: _____

