Mask Medical Exemption
(Employee)

California Department of Public Health currently requires masks indoors in K-12 schools, childcare, and other youth settings.

All employees are required to wear a mask that covers the nose, mouth, and chin while they are on campus. A face covering is defined as a surgical mask, a medical procedure mask, a respirator worn voluntarily, or fabric with at least 2 layers. Exemptions or alternatives may be considered for people with a documented medical condition, mental health, or disability that prevents wearing a mask as well as persons who are hearing impaired. It is your responsibility to provide the appropriate documentation from your medical provider; must be made by a physician, nurse practitioner, or other licensed medical professional practicing under the license of a physician.
https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/guidance-for-face-coverings.aspx

Employee Name:_____ Date of Birth:_____

Signature:_____ School Site:_____

I understand that the confidentiality of disclosed information is protected by the Family Educational Rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act (HIPAA) and will be shared only as needed with appropriate staff.

TO BE COMPLETED BY THE AUTHORIZED MEDICAL PROVIDER

This employee has requested an exemption to the requirement of a mask. As a result, Summerville Union High School District requires medical verification for the following information.

This employee has a medical condition as defined by the California Department of Public Health/Centers for Disease Control and Prevention that makes them exempt from the face covering requirement.

☐ Yes ☐ No
If yes, reason for exemption: _____

☐ I have evaluated the employee and found the following alternative to be effective:

☐ Face Shield with Drape ☐ Face Shield ☐ Mask with fresh air breaks ☐ Plexi-glass partitions
☐ Other:

_____
_____

OR

☐ As the employee's medical provider, I attest that no suitable alternatives to the face covering can be found to meet this requirement.

As the employee's authorized medical provider, I understand the information provided will be used to assist the employer, and the employer will determine how this medical verification affects the employee's ability to perform their job. This includes those who are considered an essential service employee as defined by the CDPH. I have discussed these risks with the employee following CDC, CDPH, and Cal OSHA guidelines to decrease risk of exposure. The employer will determine the availability or reasonableness of any accommodations to address limitations and/or restrictions.

Medical Provider Information:

HEALTH-CARE PROVIDER'S PRINTED NAME: _____

ADDRESS: _____

PHONE: _____ **FAX:** _____

SIGNATURE OF PROVIDER: _____ **DATE:** _____