Face Mask
Medical Accommodation Request

Dinwiddie County Public Schools
2021-2022

Student Information (To be completed by Parent/Guardian):	
Student Last Name:	Student First Name:
Date of Birth:	Grade:
Parent/Guardian Phone:	Parent/Guardian Email:
School:	

I request that Dinwiddie County Public Schools (DCPS) staff review the recommendation regarding the use of a face mask while in the school building and during school provided transportation. I understand that:

1. The Federal Center for Disease Control and Prevention (CDC) recommends universal indoor masking for all teachers, staff, students, and visitors to K-12 schools, regardless of vaccination status.
2. If my child does not wear a face mask while in the school building and during school provided transportation, then my child may be at increased risk of contracting Covid-19;
3. To protect others from the transmission of Covid-19, the school staff may take additional virus transmission mitigation precautions, including: requiring my child to wear a face shield; requiring my child to use a protective barrier around their desk; requiring my child to be physically distanced (more than 6 feet from other students), etc.;
4. The school may consider alternative learning environments for my child, including placement in a separate classroom or at a different school building; and
5. Based upon information provided by me or my child's doctor, my child may be referred for an evaluation to determine if my child's medical condition results in my child being eligible as a student with a disability.

My signature gives permission to Dinwiddie County Public Schools staff to exchange information with the physician/physicians' office and to discuss my child with the physician/physician's office. This release allows the physician/physician's office to exchange with DCPS educational, medical, sociological, psychological, psychiatric, and treatment records, and information related to these records. The designation of one or more contact persons is to facilitate communication and does not restrict access of information to and from the physician/physician's office and DCPS unless so specified. The purpose of exchanging records and information with the physician/physician's office is to provide DCPS with information that may be used in the coordination or provision of services to the student.

Parent/Guardian Signature: _____ Date: _____

Submitting this form does not guarantee that your request will be granted.

This completed form must be returned in its entirety to the DCPS Student Services Coordinator, Michelle Powell, via fax at 804-469-4197 or via email to cpowell@dcpsnet.org.

The following must be completed by a Licensed Physician:
Physician Name:
Physician Specialty:
Office Address:
Phone Number:
Student Diagnosis / Medical Condition: _____
Description of Student's Medical Condition: _____ _____ _____ _____

I certify that I have examined the student identified and it is my professional opinion that: [check all that apply]

- ☐ The student is medically able to wear a face covering at school.
- ☐ The student has a medical condition, but the student can wear a face mask at school if accommodations are provided (e.g. periodic breaks).
- ☐ The student has a medical condition which requires, as a medical necessity, an exemption from the requirement to wear a face mask.
- ☐ Other (please explain): _____

Extent and duration of this request: _____ _____
Explanation of why an exemption from the requirement to wear a face mask is medically necessary for this student: _____ _____ _____

Attach any supporting documentation that may be helpful in evaluating this request for an exemption from the mask requirement.

Physician Signature: _____ Date: _____

DCPS Internal Use Only

Date Received: _____ Approved: ☐ Yes ☐ No Parent Notification: _____

SBO Staff Signature: _____ School Notification: _____