Certificate of Face Covering Exemption
Medical Exemption

Last Name _____ First Name_____

The above named applicant qualifies for a medical exemption from wearing a required face covering when physical distancing cannot be achieved in the public school setting. If, in the opinion of the physician, nurse practitioner, physician assistant, or licensed mental health therapist issuing the medical exemption, the exemption should be terminated or reviewed at a future date, an expiration date shall be recorded on the Certificate of Face Covering Exemption.

Certificate Expiration Date: _____

The child granted the exemption is subject to the same quarantine and other disease prevention measures recommended by public health services and implemented by the school district.

By signing this certificate, I certify that wearing a face covering at school would be injurious to the health and well-being of the applicant.

Name (Print): _____
Physician, Physician Assistant, Nurse Practitioner, or Licensed Mental Health Therapist

Iowa License Number: _____
Physician, Physician Assistant, Nurse Practitioner, or Licensed Mental Health Therapist

Signature: _____
Physician, Physician Assistant, Nurse Practitioner, or Licensed Mental Health Therapist

*Certificate Adapted from Iowa Department of Public Health Immunization Exemption
** Physical distancing guidelines will need to be strictly oberserved.