Alloway Township School
P.O. Box 327, 43 Cedar St.
Alloway, NJ 08001
(856) 935-1622

Pamela Southard, Chief School Administrator - Shannon DuBois-Brody, Business Administrator

Parent Request for Face Mask Exemption Due to Medical Condition

Please complete both pages of the following form in its entirety. Attach the Medical Documentation from the student's local health care provider.

Student's Name:	Grade:
School:	Classroom/Homeroom Teacher:
Parent/Guardian Name:	
Parent/Guardian Contact Number:	
Local Health Care Provider (Physician) Name and Address:	
Date of Physician's Determination:	

Submit all documentation to Kellie Whelan, School Nurse, at whelank@allowayschool.org, fax 856-935-3017.

NOTE: Once received, [insert name and title of the appropriate District personnel] shall forward the written documentation from the student's local health care provider, parent-signed release of information form, and any additional appropriate information to the school physician, who shall verify the need for a mask exemption. The school physician may then contact the student's physician to secure additional information concerning the student's diagnosis or need for exemption and shall either verify the need or shall provide reasons for denial to the district board of education. This process may be delayed if the student's health care provider does not respond to a request for information from the district school physician. No mask exemption will be granted until approval is received from the school physician.

The parent/guardian will be notified when approval is received.

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AUTHORIZATION TO RELEASE / OBTAIN RECORDS OR INFORMATION
FOR MASK EXEMPTION DUE TO MEDICAL CONDITION REQUEST

Student's Name: _____

Date of Birth: _____ School: _____

I hereby authorize (name/address/phone number of local health care provider):
_____
_____
_____
_____
_____

To release information/records to:

Kellie Whelan, School Nurse, the Alloway Township School designee

I understand the information to be released may include the following in written and/or verbal form:
Reports and Consultations
Diagnostic Tests, Results and Interpretations
Medical Records
History Diagnosis and Treatment Plans

The authorization shall become effective on the date signed and remain in effect until revoked by me. I may void this authorization, except for action already taken, at any time by providing notice in writing.

_____ _____
Parent / Guardian Signature Date

Print Name:_____ Relationship to Student: _____