STATE OF HAWAII
DEPARTMENT OF EDUCATION

REQUEST FOR FACE MASK EXEMPTION IN SCHOOL

School Name:_____

School Year:_____

Please complete form in ink Student's First and Last Name:		Date of Birth: (MM/DD/YYYY)
Address:	City:	Zip:
	State:	
Parent 1 First and Name:	Cell:	Other phone:
Parent 2 First and Name:	Cell:	Other phone:
Legal Guardian First and Last Name:	Cell:	Other phone::

I am aware that few medical conditions are truly incompatible with all forms of mask wearing. However, I confirm that this patient is under my medical care and it is my medical assessment and recommendation that this patient be exempted from wearing a face mask because of the following medical contraindications: **(check one or more of the following)**

☐ Unable to remove the mask without assistance

☐ Has trouble breathing with various appropriate face masks despite medical treatment

☐ Face mask may exacerbate a physical or mental health condition, lead to a medical emergency, or introduce significant safety concerns.

I have informed the patient and/or patient's guardian that wearing a face mask is effective at preventing the transmission of the virus that causes COVID-19 by containing the spread of respiratory droplets and helping reduce inhalation of these droplets by the wearer.

Duration of exemption **(check one of the following)**:
☐ Begin date _____ (MM/DD/YYYY) and end date _____ (MM/DD/YYYY)
☐ Permanent

Provider Signature: _____ **Date:** _____

Provider Name (type/print): _____ **Phone:** _____ **Fax:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

☐ I am a U.S. licensed physician, APRN, or PA (required) License Number:_____