



APSB Face Covering Accommodation Request Form- Students

Student Name		Grade	
Homeroom teacher			
<b>Face covering is mandated at APSB facilities. Request for accommodations or exclusion must be approved once submitted.</b>			
<b>REQUESTED/ SUGGESTED ACCOMMODATION (Please CHECK ONE):</b> _____ Medical condition *Requires Physician's Approval (See below) _____ IEP (Special Education) Disability (requires IEP team decision) _____ 504 plan accommodations (requires 504 team decision)			
<b>MUST BE COMPLETED AND SIGNED BY PHYSICIAN'S OFFICE</b> <b>NATURE OF THE QUALIFYING DISABILITY</b> Please describe <b>specifically</b> the nature, extent, and duration of your patient's disability.			
<b>PHYSICIAN CONTACT INFORMATION</b> Please provide name, address, telephone, and fax numbers. The physician may receive a letter/fax from us requesting additional information on your child's impairment/disability and recommendations for accommodations. Physician name _____ Telephone number _____ Address _____ Fax number _____ Physician signature _____			
<b>School Nurse Signature</b> _____ _____ Approve _____ Deny			Date
<b>Principal Signature</b> _____ _____ Approve _____ Deny			Date
I authorize the release of necessary confidential medical information regarding my child's disability to relevant employees as deemed necessary by the school nurse, Principal, IEP team, 504 team and/or other administrators. By signing this form and not wearing a proper face covering, I acknowledge that my child is at an increased risk of contractive COVID-19 and infecting others. Parent/Guardian signature _____ Date _____			
<b>Failure to follow these accommodation agreements may result in loss of permission to access campus.</b>			