Coeur d'Alene School District No. 271

(Emergency)

THE BOARD OF TRUSTEES **1207 F**

MEDICAL VERIFICATION FOR MODIFICATION TO MASK POLICY - FORM

DATE: _____

Name/Title of Physician completing form:

_____

Name of Patient:

_____

Description of Medical Condition necessitating modification of mask policy (please describe the disability, the needed modification and the relationship between the disability and the requested modification):

_____
_____
_____
_____
_____
_____
_____

Proposed Accommodation:

_____
_____
_____
_____
_____

By signing below, I the undersigned physician am verifying that my patient has the foregoing disability that necessitates a modification to the Coeur d'Alene School District's mandatory mask policy.

_____
Signature

_____
Printed Name