Los Rios Community College District

Student COVID-19 Face Mask Medical Exemption Request Form

Consistent with public health authority directives, all Los Rios Community College District students must wear face coverings when indoors at any Los Rios facility.

If you have a medical condition, mental health condition, communication disability, or other disability that precludes you from wearing a face covering and you seek an exemption from the Los Rios COVID-19 face covering requirements, please consult with your physician, mental health counselor, therapist, or medical professional and complete this form.

This Section to be Completed by the Student

Please provide the following information:

Name: _____ Student ID#: _____

E-mail: _____ Phone #: _____

Physician, Counselor, Therapist, or Medical Professional's Name: _____

Physician's Phone #: _____ Email Address: _____

Physician, Counselor, Therapist, or Medical Professional's Address:

_____

_____

_____

Student Verification

I verify that the information I am submitting in support of my request for a medical exemption to the Los Rios face covering requirement is complete and accurate to the best of my knowledge, and I understand that any intentional misrepresentation contained in this request will result in disciplinary action.

I understand that the information provided may be used by the District to help determine eligibility for and to identify possible reasonable modifications or accommodations. I understand that if I refuse to provide the information requested, my refusal may impact the District's ability to adequately understand my request or effectively identify possible reasonable modifications or accommodations.

I also understand that my request for a modification or accommodation may not be granted if the modification or accommodation would result in a fundamental alteration of the academic program, impose an undue financial or administrative burden on the College, or would result in a significant risk or direct threat to the health & safety of others.

Student Signature: _____ Date: _____

Print Name: _____

This Section to be Completed by the Physician, Counselor, Therapist, or Medical Professional

Dear Physician, Counselor, Therapist, or Medical Professional:

In order to promote a safe and healthy work and academic environment, the Los Rios Community College District has set forth directives and policies regarding COVID-19 and has implemented a requirement that all District students wear face coverings when inside any District facility. If your patient has a medical or mental health condition that prevents them from wearing a face covering, please provide a signed note on official letterhead identifying your patient's specific medical restrictions and complete the following:

Patient/Student's Name: _____

QUESTION 1: Does the student have a (check all that apply):

☐ Medical condition

☐ Mental health condition

☐ Disability

☐ Communication Disability

****IF NONE OF THE ABOVE ARE CHECKED, STOP HERE, AN EXEMPTION DOES NOT EXIST**

QUESTION 2: Does the medical condition, mental health condition, communication disability or other disability:

☐ Prevent or prohibit the student from wearing a face covering?

☐ For communication disabilities only: Does the student have a communication disability, or would a face covering inhibit communication with a person who is deaf or hard of hearing?

****IF NONE OF THE ABOVE ARE CHECKED, STOP HERE, AN EXEMPTION DOES NOT EXIST**

QUESTION 3: Can the student wear an alternative face covering?

☐ Yes, the student can wear a face shield with a drape.

☐ Yes, the student has a communication disability and can wear a clear face covering or a cloth face covering with clear panel, or a face shield with a drape.

☐ Yes, the student can wear an alternative. Other alternative: _____

☐ No, the student cannot wear an alternative face covering.

Physician, Counselor, Therapist, or Medical Professional Certification

I certify that the information I have provided herein is correct.

Signature: _____ Date: _____

(Note: Signature Stamp Not Acceptable)

Title: _____ License or Certification #: _____