

Face Covering Accommodation Request

This form must be completed in its entirety by parents/guardians who are requesting an accommodation to the MSHSL and ISD 701 Face Covering Policy. This completed form should be turned into the activities director who will work with Student Services to review and approve the accommodation. The district may verify all information provided.

Please note, per Fairview - Hibbing, Mt. Iron and Nashwauk, St. Luke's - Hibbing Family Medical Center and Laurentian Medical Center, and Essentia - Hibbing:

If an individual's respiratory status is tenuous enough not to tolerate masking, they are too high a risk to be playing during this pandemic. This is in accordance with the AAP as well as MN Pulmonology and critical care recommendations. This is also supported by the MN Mental Health Associates per St Luke's.

Sport:	
Student Name:	Date of Birth:
Email Address:	
My student has a current:	
<input type="checkbox"/> Health Care Plan (name of child's medical provider: _____) *Please attach an asthma action plan or allergy action plan.	
<input type="checkbox"/> New health condition (name of child's medical provider: _____)	

Please identify the accommodation you are requesting for your child:

Please identify the reason for the request for accommodation:

****All medications and supplies must be readily available near the student-athlete's water bottle or on the bench in a visible location and packaged with the student-athlete's name. Packaging must be self-contained and may include zip-lock bags, Tupperware/Rubbermaid container, etc.****

I authorize the district and the medical provider(s) listed above to mutually exchange information, including conversations, related to my child's medical condition and the impact it may have on the student's ability to comply with the MSHSL and ISD 701 Face Covering Policy. This authorization is valid for one calendar year unless otherwise revoked in writing. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I understand that failing to authorize disclosure of information may impact the district's ability to grant my request for reasonable accommodations. I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain a free education.

Parent Signature: _____ Date: _____

(for use by ISD 701 Staff only)

Approval of Accommodations

	Check the appropriate box below	Additional Notes
The district approves the request for accommodations as noted above.		
The district does not approve the request for accommodations as noted above.		

Administrator Signature: _____ Date: _____