



Diocese of Greensburg

Face Covering Exemption Form

Student Name: _____

Date of Birth: ____ / ____ / ____

School Name: _____

To be completed by Physician's Office ONLY:

Please check one or both of the following:

The above-named individual **cannot** wear a face mask due to a medical condition.

If the individual is unable to wear a face mask, is the individual able to tolerate a face shield?

Yes

No

Physician's Name: _____

Physician's Signature: _____

Date: ____ / ____ / ____

Phone Number: _____
