

Troy Area School District
Office of Support Services

REQUEST FOR MASK ACCOMMODATION:COVID-19

Student Name: _____ Grade: _____

Address: _____ DOB: _____

School : _____ Homeroom Teacher: _____

The Troy Area School District uses an interactive process to determine if a student has a disability that prevents them from wearing of a mask/face covering to minimize the transmission of COVID-19, as set forth in the district's Health and Safety Plan. As part of the interactive process, the district must receive information from the student's health care provider.

The following is a summary of the district's plan for the use of masks/face coverings:

- Masks must be worn by students and staff at school and on the bus as required by order signed by Sec. of Health Dr. Levine on July 1.
- This Order applies to any individual aged two and older whenever outside the home, including while in school entities, including public K-12 schools.
- All students must wear a face covering (cloth mask or shield) that covers their nose and mouth inside the school and while outside when physical distancing is not feasible.
- Face coverings, such as masks or face shields, must be worn by all non-students, both staff and visitors (including parents and guardians), while on school property, including during student drop-off and pickup.
- Face coverings are not expected while actively eating or when social distancing (6 feet) is feasible.

Please answer the following questions:

1. ()YES ()NO Does the student have an impairment that limits one of more major life activities?

"Major life activities" can include, for example, speaking, reading, concentrating, thinking, and communicating.

If YES: check the major life activity that is affected by the impairment:

- | | | | |
|--|----------------------------------|--|--|
| <input type="checkbox"/> Caring for Self | <input type="checkbox"/> Hearing | <input type="checkbox"/> Working | <input type="checkbox"/> Performing Manual Tasks |
| <input type="checkbox"/> Speaking | <input type="checkbox"/> Reading | <input type="checkbox"/> Walking | <input type="checkbox"/> Breathing |
| <input type="checkbox"/> Concentrating | <input type="checkbox"/> Seeing | <input type="checkbox"/> Learning | <input type="checkbox"/> Thinking |
| <input type="checkbox"/> Communicating | <input type="checkbox"/> Eating | <input type="checkbox"/> Sleeping | <input type="checkbox"/> Standing |
| <input type="checkbox"/> Lifting | <input type="checkbox"/> Bending | <input type="checkbox"/> Bowel Functions | <input type="checkbox"/> Bladder Functions |
| <input type="checkbox"/> Other | | | |

If Other, please explain:

2. Is the student substantially limited in the identified major life activity (ies)? Complete the scale below:

Place a check on the following scale to indicate the specific degree that the impairment limits the major life activity:

- 5 () Extremely
- 4 () Substantially
- 3 () Moderately
- 2 () Mildly
- 1 () Negligibly

3. () YES () NO Does the student’s impairment limit their ability to wear a mask/facial covering while attending school?

If yes, please explain the limitation(s) and the reason for the limitation and describe any modifications to the district’s plan for use of masks/facial coverings that you believe should be considered.

If there are any questions regarding this form, please call the Office of Support Services at 570-297-2730.

Diagnosis: _____

Signature of Attending Physician/Psychiatrist

Date

Print name of Attending Physician/Psychiatrist

Phone number of Physician/Psychiatrist

***Release of Confidential Information is also required and should be provided to T ASD with this form.**