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**CARROLL COLLEGE MARCHING FORWARD COVID-19 MASK REQUIREMENT**

**MEDICAL EXEMPTION REQUEST FORM – STUDENTS**

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| Student First Name |  | Carroll I.D. # |  |
| Student Last Name |  | Home/Cell Phone |  |
|  |  | e-mail address |  |

This form is for students who are requesting a medical exemption from Carroll College’s Marching Forward COVID-19 mask requirements. Once completed, please submit your form to the Carroll College Wellness Center. The address can be found at the bottom of page 2.

In order to receive a medical mask exemption, a physician licensed to practice medicine in any jurisdiction of the United States must sign this form. This form also must be filled out and signed by the student.

**SECTION 1: TO BE COMPLETED BY PHYSICIAN**

**Physician’s Declaration**

I declare that the above-named patient, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, consulted with me on wearing a mask or face covering as it relates to the COVID-19 (SARS-CoV-2) virus. I have discussed the benefits and risks of wearing a face covering/mask with the patient and/or the patient’s parent/legal guardian relative to the patient’s health concerns and certify that a medical face covering/mask exemption is warranted due to the patient’s existing medical condition.

**Physician’s Initial \_\_\_\_\_\_\_**

I certify that I am a physician licensed to practice medicine in the United States, and the information provided on this form is complete and correct.

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| Physician’s Name (Print) |  | Physician’s National Provider Identifier (NPI) (Required)  |  |
| Physician’s Signature |  | Physician’s Address |  |
| Date (mm/dd/yyyy) |  | Physician’s Office/Work Phone |  |

The information provided will be reviewed by Carroll College Wellness Center. You may be contacted for clarification if needed. Medical accommodations will remain in place for one academic year and must be renewed annually.

**Student must read the following and initial and sign:**

1. I understand that COVID-19 is a serious viral illness and the Centers for Disease Control and Prevention (CDC), American College Health Association (ACHA), Montana Department of Public Health and Human Services (MT DPHHS), and Lewis and Clark County Public Health Department strongly encourage wearing face coverings and/or masks to mitigate against the spread of the virus. **Initial \_\_\_\_**
2. I also understand that Carroll College may require everyone on College owned premises to wear masks, regardless of vaccination status, as long as there is a provision for accommodations for persons based on sincerely held religious beliefs or disability. I also understand that Carroll College will not discriminate against anyone who requests such an accommodation. **Initial \_\_\_\_\_**
3. I understand that Carroll College reserves the right to request additional documentation. If approved, this exemption will only remain in effect for the duration of the current academic year. I understand requests must be renewed annually. **Initial \_\_\_**

**Student Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_**

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| CARROLL COLLEGE WELLNESS CENTER OFFICE USE ONLY | Kerri Rigsby, RNDirector of Wellness CenterGuadalupe Hall – Room 008HPhone – 406-447-5438krigsby@carroll.edu |
| Approved By:  |  |
| Date: |  |