

CERTIFICATION OF EXEMPTION FROM MASK REQUIREMENTS

At this time the Waukee Community School District ("District") is requiring the use of facial coverings or masks ("Mask") in certain designated classrooms as may be otherwise required by law ("Mask Requirement").

By signing this Certification of Exemption, you represent and attest **under penalty of perjury** that you or your child is eligible for exemption from the District's Mask Requirement as set forth below:

_____ (Name) _____ (Date of Birth)

_____ qualifies for the requested exemption because, in the opinion of an Iowa licensed physician (MD or DO), nurse practitioner, or physician assistant, such requirements are medically contraindicated as Masks would be injurious to the health and well-being of the person. **If you have medical documentation in support of your request for exemption, please attach it to this form before submitting.** If no documentation is attached upon submission, the District, reserves the right as legally authorized to ask for additional medical documentation to verify the person's health condition and its impact on the Mask Requirement as well as to assess possible modifications to such requirements or other accommodations.

_____ qualifies because such requirements conflict with a **genuine and sincere religious belief** held by the person, which is in fact religious and not based merely on philosophical, scientific, moral, personal, or medical opposition to Masks.

By signing this Certification of Exemption from the District's Mask Requirement, you further acknowledge and understand that failure to use Masks may increase the risk to yourself and others, of contracting, carrying, and spreading COVID-19 infection. Alternatives to masks may be implemented as a reasonable accommodation, if appropriate. A person granted an exemption may be subject to alternative mitigation measures.

I certify under penalty of perjury and pursuant to the laws of the State of Iowa that the preceding is true and correct.

_____ Parent/Guardian Signature _____ Print Name _____ Date

Sworn and subscribed to before me, a Notary Public in and for the State of Iowa, this _____ day of _____, 20____.

_____ Notary Public

For medical exemption:

_____ MD/DO/NP/PA Signature _____ Print Name and License No. _____ Date

(If medical exemption will end at a future date, please state date of expiration: _____)