COVID-19 TESTING
STUDENT MEDICAL EXEMPTION REQUEST FORM
(completed by medical provider)

Printed Full Name: _____

Student ID: _____ Date of Birth: _____

I, _____[print name of licensed MD, DO, PA, NP] hereby certify that the above-named student has: A medical condition that is contraindicated to his/her being tested for COVID-19 weekly:

Please check the appropriate box and describe below:

❑ There is an applicable CDC contraindication to weekly COVID testing.

❑ There is an applicable manufacturer's contraindication to weekly testing.

❑ There is a physical condition of the person or medical circumstance relating to the person that are such that weekly testing is not considered safe.

*REQUIRED: Description of contraindication, physical condition, or medical circumstance meeting criteria above:

_____

_____

_____

This contraindication, condition, or circumstance is: ◯ Permanent ◯ Temporary

If temporary, the expiration date of the exemption:

Signature of Medical Provider: _____ Date: _____

Medical License Number & State/Country of Issue: _____

Providers Address, Phone Number & Email (print or stamp):

Name of Parent/Guardian (print): _____

Parent/Guardian signature:_____ Date: _____