DIOCESE OF
TRENTON
Department of Catholic Schools

Diocese of Trenton
REQUEST FOR MEDICAL EXEMPTION FROM MANDATORY MASK WEARING AS PER EXECUTIVE ORDER 251

SCHOOL PATIENT IS ATTENDING: _____

Name of Student (Patient): _____

Patient Date of Birth: _____

Name of Parent/Guardian: _____

Patient/Parent Home Address: _____

Patient/Parent Email Address: _____

Exemption Length:

Beginning Date _____

Ending Date _____

Diagnosis and Contraindications:

_____

_____

_____

_____

_____

PHYSICIAN ATTESTATION

I am a physician (M.D. or D.O) licensed to practice medicine in a jurisdiction of the United States.

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By signing below, I affirm the above diagnosis and contraindication(s). I understand that I might be required to submit supporting medical documentation. I also understand that any misrepresentation might result in referral to the New Jersey State Board of Medical Examiners and/or appropriate licensing/regulatory agency.

Healthcare Provider Name (please print): _____

Specialty: _____ NPI Number: _____

License Number: _____ State of Licensure: _____

Phone: _____ Email: _____

Address: _____

City: _____ State: _____ Zip: _____

Signature: _____ Date: _____

PLEASE ATTACH A SIGNED PRESCRIPTION INCLUDING THE PATIENT'S NAME AND STATE CONTRAINDICATIONS DUE TO MASK WEARING.