EARTHROOTS
Deepening our Connections with Nature

AUTHORIZED HEALTHCARE PROVIDER
MASK EXEMPTION FORM

This form is being completed so that a participant will be exempt from wearing a mask as advised by medical professionals for COVID-19 protection.

Participant Name:_____ Birthdate:_____

Class/Instructor:_____ Phone:_____

I, _____, agree to adhere to a minimum of 6 feet physical distancing at all times while interacting with Earthroots Field School staff and participants.

Participant Signature:_____ Date: _____
If the participant is a minor, parent/guardian must sign.

Please print parent/guardian name: _____

The following section is to be completed by an authorized healthcare provider.

Reason for Exemption: _____

Possible medication reactions:_____

Instructions for emergency care:_____

Authorized Healthcare Provider Name (print clearly):_____

Telephone:_____ Date of Request:_____

It is my professional opinion that this participant should be exempt from wearing a mask as advised by medical professionals for COVID-19 protection.

Authorized Healthcare Provider Signature:_____

www.earthrootsfieldschool.org

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**This request is valid for a maximum of one year.