SCHOOL DISTRICT 189 CERTIFICATE OF PHYSICAL INABILITY TO PARTICIPATE IN THE REQUIRED SALIVA PCR TESTING

PARENT OR LEGAL GUARDIAN - COMPLETE THIS SECTION

Note: *This form is required for all students attending in-person schooling at East St. Louis District 189 when parent(s) or legal guardian(s) is requesting a physical inability exemption.*

This form may NOT be used for personal or philosophical reasons.

Student's Full Name:		**Student's Date of Birth:**
Parent/Guardian Name:		**School Name:**
Complete Address:		**Grade:**
Telephone Number:		**Gender:**
Exemption Requested for: SHIELD Illinois Saliva PCR testing		

To receive an exemption to saliva PCR testing, a parent or legal guardian must provide a statement detailing the physical inability that prevents the child from participating in the required saliva PCR testing being requested. In the space provided below, state the saliva PCR testing exemption requested and state the physical inability for such request. If additional space is needed, attach additional page(s).

Physical Inability Exemption Notice: No student that has a physical inability is required to participate in the saliva PCR testing. However, not participating in the saliva PCR testing may endanger the health or life of the student, others with whom they come in contact, and individuals in the community. I have read the Physical Inability Exemption Notice (above) and have provided requested information for saliva PCR testing physical inability exemption.

Signature of parent or legal guardian (required) **Date**

HEALTH CARE PROVIDER* – COMPLETE THIS SECTION

Provision of information: I have provided the parent or legal guardian of the student named above, with information regarding 1) the required saliva PCR testing and 2) the health risks to the student and to the community from COVID-19. I understand that my signature only reflects that this information was provided; I am not affirming the parent or legal guardian's religious beliefs regarding any saliva PCR testing.

Health Care Provider Name:	
Signature of health care provider* (required)	**Address:**
Date Telephone #:	

**Health care providers responsible for performing child's health examinations include physicians licensed to practice medicine in all of its branches, advanced practice nurses, or physician assistants.*