Nixa Public Schools
Mask Accommodation Request (Treating Professional Form-Student)

Name of individual requesting accommodation: _____
Date of birth: _____School Attending: _____
Treating Professional's name and title: _____

The above named individual has requested an accommodation relating to the mask/face covering policy of Nixa Public Schools. In order to comply with the Americans with Disabilities Act, this form is intended to evaluate the person's request for an accommodation.

As the professional identified by the individual or parent/guardian as providing treatment relating to this mask accommodation request, Nixa Public Schools requests that you provide answers to the following questions to the best of your ability.

1. What is the individual's condition and, in your opinion, is the individual substantially limited in any major life activity because of his or her condition? If so, identify the major life activities that are substantially limited._____
   _____
2. What is your general relationship with the individual for the condition in which the accommodation is requested (i.e., primary care, ongoing therapeutic relationship, single session to review need for accommodation)? _____
   _____
3. How long have you treated/known the individual? _____
4. Is your principal clinical relationship with the individual for the condition for which the accommodation is requested? _____
5. What is your understanding of the accommodation requested? _____
   _____
6. Can the individual perform all of the functions of an academic school environment without accommodations? If no, please list the functions the individual is unable to perform or will have difficulty performing and explain the extent and duration of the limitation and what accommodations are recommended. _____
   _____
   _____
7. If approved, do you foresee any additional challenges for the individual that need to be considered or addressed in a particular way relating to this request? _____
   _____
   _____

Signature of treating professional _____
Printed Name of treating professional _____
Specialty _____ Today's Date _____
Clinic Name _____ Clinic Phone _____
Clinic Address _____

Return to the Nixa Public Schools Special Services Department at 301 S. Main St.