(1)

DOCUMENTS FOR EXAM DAY WITH THE DOCTOR

Parents name:_____ **date**_____
Cell #:_____
Email:_____
Address:_____
_____
Child's name:_____ **DOB:**_____
Child's name:_____**DOB:**_____
Child's name:_____ **DOB:**_____
Child's name:_____**DOB:**_____

Parents forms:

Please complete this page for all of the kids to be seen today
School waiver form (generic or school specific)
Dr. Taylor's waiver form
Dr. Taylor's consent form
Your child's exam form
Please bring a copy of your child's *most recent doctor exam* and a *signed and dated personal statement* from you detailing medically, emotionally, or physically why you want your child to be mask free. Detail behavioral changes that have occurred since mask use at school and how you treat the problem.

Process:

Parents provide personal, signed, dated statement for each child
Parents provide copy of most recent office visit for each child
Parents complete as much of the forms as possible
Dr. Taylor offers credentials for parents to review
Dr. Taylor reviews documents and explains consent/parent signs
Dr. Taylor provides exam/obtains photo of child with parent presence/consent
Dr. Taylor completes all forms-to Captain to provide copy (Dr. T) and originals (parent) *Please* provide any follow-up of the process with any complications. We can always improve!

(2)

MEDICAL WAIVER FOR FACE MASKS

Persons who are medically unable to tolerate wearing a face mask can seek a waiver signed by a physician that indicates a medical reason for exemption from the requirement.

Student Name: _____

Date of Birth: _____

School Name: _____

INFORMATION BELOW MUST BE COMPLETED BY YOUR MEDICAL OR OSTEOPATHIC PHYSICIAN:

The above-named individual requires documentation from a medical or osteopathic doctor that they are unable to wear a facial covering during the current school year due to a medical condition. Schools are required to obtain this documentation as they are with any other accommodation*. We appreciate your time and assistance in this matter.

The above-named individual cannot medically tolerate a face covering due to the following medical condition: Cardiovscular-or-dermatologic-or-mechanical-or-neurologic-or-psychologic-or-respiratory medically qualifying condition per MCL 333.2253(5)(c)

I, hereby certify that the medical condition would _X_ cause trouble breathing or _____ make the student unable to remove the cloth face covering without assistance or would cause the following deleterious problem: as above.

If unable to medically tolerate a face covering, this student is able to use a face shield:

_____Yes

__X__No

_____ If not, why not: as above.

Medical or Osteopathic Physician's name and licensure: James A. Taylor, DO, PC Family Physician
4219 Maybeck Drive, NE
Grand Rapids, MI 49525

Please Print

Physician's Signature: _____

Date: _____

Phone Number: (616)724-4877

I hereby agree with and authorize any restrictions or limitations described above pertaining to my child or ward.

Parent or Guardian Signature: _____

*This list of acceptable conditions along with the guidance for schools to require this documentation from a medical professional has been provided by the state of Michigan and can be found at https://www.miottawa.org/Health/OCHD/pdf/Face-Masks-In Educational-Settings-Order_082021.pdf .

August 23, 2021

(3)

James A. Taylor DO PC Board Certified Family Physician
4219 Maybeck Dr. N.E. Grand Rapids, MI 49525
Office: 616-724-4877 fax: 616-724-4641

_____, DOB: _____ cannot and should not tolerate a face covering due to a covered medical condition. HIPAA law prevents release of the associated diagnosis as it violates patient privacy. A face covering shall exacerbate his/her medical condition and place him/her at significant medical risk. A face shield is not an appropriate alternative as it continues to restrict air flow and does not provide any air filtration or significant deviation of air flow.

_____ _____
James A. Taylor DO date

(4)

DR. TAYLOR'S CONSENT FORM for providing mask exemption

Thank you for requesting this evaluation for your child/self_____
for appropriate mask exemption status DOB_____

You have provided documentation (attached) which I have reviewed in detail with you. This documentation is private and will not be released without your permission as it falls under HIPAA guidelines. If requested, you will be responsible for supplying the required documents.

___I do not agree to release of medical information, OR:
___ I agree to release medical information to the following:
____my physician _____
____other healthcare entities (please list) _____
____schools or other requesting agencies (please list) _____

You agree to allow me, in your presence, to examine your child for evidence of medical, emotional, or psychological factors which may support your claim for mask exemption.

I am not acting as or replacing your child's/self primary care physician and shall not assume future responsibility for his/her/your care. You should continue with your medical treatment team without interruption from this evaluation.

This document is valid for one year beginning the date of signature and reevaluation should take place prior to expiration of the document due to changing medical/environmental conditions.

As parent/guardian/self of my child/self, I shall hold Dr. Taylor and his corporation harmless from any/all causes, actions, claims, demands, losses, costs, damages, legal actions, and expenses of any nature arising out of subsequent exposure to, contraction of, or transmission of any communicable disease which may cause personal injury or death because of and consequences of this mask mandate exemption document.

By signing this document, you agree in full to the contents herein.

_____ _____
Parent/self date

_____
Printed name

_____ _____
James A. Taylor DO date

Copy received by signators _____/_____
Revised 01-25-2022

DATE NAME TIME IN: OUT: TOTAL (5)

Chief Complaint:

Parent Present: Child's DOB:

BP	ALLERGIES
P	
T	MEDS
HT	
WT	
LMP	
SMOKER	
ALCOHOL	

Primary Care Physician:

EXAMINED/ROS ✓ = normal PROBLEMS

☐ Prior documentation, history and exam reviewed in part for this visit ☐ Discussion x ____minutes

☐ Awake Alert Oriented x 3 ☐ No Apparent Distress ☐ No Mood Thought Disturbance ☐ Judgement Sound

☐ PERL/EOMI Conjunctiva Clear

☐ TMs: R clear _____ L clear

☐ Nares Patent Without Discharge / Obstruction/ ____Septal Deviation

☐ Midline Tongue / Uvula/ Moist Mucosa ☐ No Tonsillar Enlargement/ Exudates

☐ Posterior Pharynx Pink Without Hyperemia / Drainage

☐ Neck Supple Without Adenopathy / Thyromegaly / Bruit

☐ HRRR Without Murmur. S3S4 / Click / rub / JVD

☐ Chest Without Deformity / ↑APdiameter ☐ Lungs CTA No Wheezes / rhonchi

☐ Respiration Easy / Symmetric ☐ No Nipple Discharge / Striae / Axillary Adenopathy

☐ Breasts Firm / Full / Symmetric Without Masses

☐ Abdomen Soft Flat BS+x4 ☐ No Scars/ Striae

☐ No Hepatosplenomegaly / Inguinal Adenopathy/ Bruits

☐ BUS _____ ☐ UTERUS

☐ VAGINA _____ ☐ ADNEXA

☐ CERVIX _____ ☐ Rectum/ Perineum

☐ Extremities Without Cyanosis Clubbing Edema Onchomycosis

☐ Skin Warm Dry ☐ Without Rashes Tumors Moles Warts Lesions

☐ CN II-XII Intact DTR 2/4=bilaterally UE/LE _____ ☐ touches toes ☐ problems

☐ Strength 5/5=bilaterally ☐ Romberg Normal

☐ Weber Midline ☐ RinneA>B ☐ RAM/HW - TW normal

Assessment 1 _____ 3 _____ 5 _____

2 _____ 4 _____ 6 _____

PLAN: 1

2

3 ☐ Parent Personal Statement Pending

4

5 ☐ Child's Medical Records Pending

6

7

Continue Care with your primary care physician!

NEXT VISIT PRN _____ OR _____ ☐ Risks/benfits of meds/Tx reviewed/Accepted by Patient

SIGNATURE | JAMES A. TAYLOR, D.O. ☐ Patient discharged from office STABLE