SAN FRANCISCO COMMUNITY COLLEGE DISTRICT
SARS-CoV-2 (COVID-19) VACCINATION REQUIREMENT
MEDICAL EXEMPTION AND/OR DISABILITY EXCEPTION REQUEST FORM

This form should be used by San Francisco Community College District ("District") students and employees to request an Exception to the District’s COVID-19 vaccination requirement based on (1) Medical Exemption due to a Contraindication or Precaution to COVID-19 vaccination recognized by the U.S. Centers for Disease Control and Prevention (CDC) or by the vaccines’ manufacturers; or (2) Disability.

Please check one:  □ Student  □ Employee

Name: ______________________________  Student ID/Employee ID: ___________________
Phone Number: ____________________  District Email: ______________________________

Fill out Part 1 to request a Medical Exemption due to Contraindication or Precaution.  Fill out Part 2 to request an exception based on Disability.

Part 1: Request for Medical Exemption Due to Contraindication or Precaution

□ The Contraindications or Precautions to COVID-19 vaccination recognized by the CDC or by the vaccines’ manufacturers apply to me with respect to all available COVID-19 vaccines. For that reason, I am requesting an Exception to the COVID-19 vaccination requirement based on Medical Exemption. My request is supported by the attached certification from my health care provider.

Part 2: Request for Exception Based on Disability

□ I have a disability and am requesting an Exception to the COVID-19 vaccination requirement as a disability accommodation. My request is supported by the attached certification from my health care provider.

I verify that the information I am submitting in support of my request for an exemption is complete and accurate to the best of my knowledge, and I understand that any intentional misrepresentation contained in this request may result in disciplinary action, subject to rights under applicable federal and state law.

Signature: ____________________________  Date: __________________
The San Francisco Community College District ("District") requires that its employees and students receive the COVID-19 vaccine as a condition of entry on campus. The District may grant exceptions to this requirement based on (1) Medical Exemption due to a Contraindication or Precaution to COVID-19 vaccination recognized by the U.S. Centers for Disease Control and Prevention (CDC) or by the vaccines’ manufacturers; or (2) Disability, provided that the individual’s request for such an exception is supported by a certification from their qualified licensed health care provider.

*A licensed physician, physicians’ assistant, or nurse practitioner must complete the medical exemption statement and provide their information below. Forms completed by the employee or student will not be accepted.*

**Full Name of Patient:** ______________________________  **Date of Birth:** _________________

Please complete Part 1 of this form if one or more of the Contraindications or Precautions to COVID-19 vaccination recognized by the CDC or the vaccines’ manufacturers apply to this patient. Please complete Part 2 if this patient has a disability, as defined below, that makes COVID-19 vaccination inadvisable in your professional opinion. More than one section may be completed if applicable to this patient. Important: Do not identify the patient’s diagnosis, disability, or other medical information as this document will be returned to the District.

**Part 1: Contraindication or Precaution to COVID-19 Vaccination**

**Contraindications:** CDC considers a history of the following to be a contraindication to vaccination with COVID-19 vaccines:

- Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a component of the COVID-19 vaccine
- Immediate allergic reaction of any severity to a previous dose or known (diagnosed) allergy to a component of the vaccine

**Precaution:** CDC considers a history of an immediate allergic reaction to any other vaccine or injectable therapy as a precaution but not a contraindication to vaccination. People with a history of an immediate allergic reaction to a vaccine or injectable therapy that contains multiple components, one or more of which is a component of a COVID-19 vaccine, have a precaution to vaccination with that COVID-19 vaccine, even if it is unknown which component elicited the allergic reaction.

☐ I certify that one or more of the Contraindications or Precautions recognized by the CDC or by the vaccines’ manufacturers for each of the currently available COVID-19 vaccines applies to the patient listed above. For that reason, COVID-19 vaccination...
using any of the currently available COVID-19 vaccines is inadvisable for this patient in my professional opinion. The Contraindication(s) and/or Precaution(s) is/are:

☐ Permanent       ☐ Temporary

If temporary, the expected end date is: ________________________________

Part 2: Disability That Makes the COVID-19 Vaccine Inadvisable

“Disability” is defined as a physical or mental disorder or condition that limits a major life activity and any other condition recognized as a disability under applicable law. “Disability” includes pregnancy, childbirth, or a related medical condition where reasonable accommodation is medically advisable.

☐ I certify that the patient listed above has a disability, as defined above, that makes COVID-19 vaccination inadvisable in my professional opinion. The patients disability is:
  ☐ Permanent       ☐ Temporary

If temporary, the expected end date is: ________________________________

Date: ________________________________

Name of Medical Provider: ________________________________

License Type: __________ License Number: __________ Issuing State: ______

Address: ______________________________________________________

Phone Number: _________________________________________________

Signature of Medical Provider: _________________________________