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: _____

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CERTIFICATION FROM HEALTH CARE PROVIDER

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: _____