San José Evergreen Community College District

COVID-19 Vaccine Medical Exemption Request Form

STUDENT INFORMATION

STUDENT NAME (LAST, FIRST)	STUDENT ID NUMBER	DATE OF BIRTH
NAME OF PARENT/GUARDIAN (if under 18)	COLLEGE EMAIL ADDRESS	

STREET ADDRESS	CITY	STATE	ZIP CODE

Medical contraindications and precautions for immunizations are based on the most recent General Recommendations of the Advisory Committee on Immunization Practices (ACIP)/CDC, available at https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html or https://www.cdc.gov/vaccines/covid-19/index.html or https://redbook.solutions.aap.org/redbook.aspx

Please check the website to ensure that you are reviewing the most recent CDC/ACIP information. Please note that the presence of a moderate to severe acute illness with or without fever is a precaution to administration of all vaccines. However, as acute illnesses are short-lived, medical exemptions should not be submitted for this indication.

ACIP Contraindictions and Precautions to Vaccination for Mandatory Vaccines

Vaccine	Exemption Length		ACIP Contraditions and Precautions
COVID-19 Vaccine	☐ Temporary Through:		☐ Severe allergic reaction (e.g., anaphylaxis) after previous dose or to a vaccine component
	☐ Permanent		☐ Other (explain below)

OTHER: Please explain fully and attach additional sheets as necessary.

ATTESTATION

I am a physician (M.D. or D.O) licensed to practice medicine in a jurisdiction of the United States or an advanced practice nurse licensed in a jurisdiction of the United States. By signing below, I affirm that I have reviewed the current CDC/ACIP Contraindications and Precautions and affirm that the stated contraindication(s)/precaution(s) is enumerated by the CDC/ACIP and consistent with established national standards for vaccination practices. I understand that I might be required to submit supporting medical documentation.

HEALTHCARE PROVIDER FIRST NAME	HEALTH CARE PROVIDER LAST NAME		SPECIALTY
NPI NUMBER	LICENSE NUMBER		STATE OF LICENSURE
EMAIL	PHONE		FAX
STREET ADDRESS	CITY	STATE	ZIP CODE
HEALTHCARE PROVIDER SIGNATURE			DATE