Student Immunization Medical/Disability Exemption Request Form

Student's Full Name: _____ SID: _____ Date of Birth: _____

Part A: Request for Exception Based on Medical Exemption

The above-named person has a medical condition that contraindicates their vaccination with the following vaccine(s):

- ☐ MMR (Measles, Mumps, and Rubella)
- ☐ Meningococcal conjugate
- ☐ Tdap/DTaP
- ☐ Varicella
- ☐ **ALL** currently available COVID-19 (SARS-CoV-2) vaccines
- ☐ Influenza
- ☐ Other: _____

Please check the appropriate box to indicate the reason for medical exemption request:

a) ☐ The applicable CDC contraindication or precaution to this/these vaccine(s)*, or

b) ☐ The applicable manufacturer's vaccine insert contraindication or precaution to this/these vaccine(s)*, or

c) ☐ A COVID-19 diagnosis/treatment within the past 90 days* (date of diagnosis/treatment: _____), or

d) ☐ The physical condition of the person or medical circumstances relating to the person that are such that immunization is not considered safe, indicating the specific nature of the medical condition or circumstances* that contraindicate immunization with this/these vaccine(s) **NOT ACCEPTABLE for COVID-19 vaccine, per UCOP policy**

*REQUIRED: **Description of contraindication**

_____

_____

The contraindication and/or precaution is: ☐ Permanent ☐ Temporary

If temporary, the expected end date is: _____

Part B: Request for Exception from All COVID-19 Vaccines Based on Disability

"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. Providers are asked to carefully consider risk of severe COVID-19 disease.

☐ I certify that the patient listed above has a Disability, as defined above, that makes COVID-19 vaccination inadvisable in my professional opinion.

The patient's disability is: ☐ Permanent ☐ Temporary

If temporary, the expected end date is: _____

I understand that I must comply with the Non-Pharmaceutical Interventions (e.g., face coverings, regular asymptomatic testing) for unvaccinated or not fully vaccinated individuals as a condition of my Physical Presence at any University Location/Facility or Program. These required Non-Pharmaceutical Interventions are defined by my Location's public health, environmental health and safety, occupational health, or infection prevention authorities, including the Location Vaccine Authority. I also understand that I must comply with any additional Non-Pharmaceutical Interventions applicable to my circumstances or position, as required by my Location. **BY SIGNING BELOW, I CERTIFY THAT I HAVE BEEN INFORMED OF THE RISKS OF COVID-19 INFECTION, INCLUDING LONG-TERM DISABILITY AND DEATH, BOTH FOR MYSELF AND FOR OTHERS WHOM I MAY EXPOSE TO THE DISEASE.**

_____
Student Signature

I, _____ [Name of licensed MD, DO, PA, NP] have reviewed the University of California Immunization Exemption Policy, and hereby certify the above.

_____
Signature of Licensed Healthcare Provider

_____
Date

Office Stamp (REQUIRED)

_____
Printed Name of Healthcare Provider / License No.

_____
MD/DO/PA/NP

Students: Upload this completed form as an attachment from the "Messages" page on your patient portal by selecting "Immunization Requirement Question".