



Student Request for Medical Exemption: COVID-19 Vaccine

Name: _____

G#: _____

College: _____

SMCCCD Email: _____

Phone: _____

SMCCCD Policy 2.90 requires that all students accessing on-site instruction and services receive a COVID-19 vaccination. A medical exemption may be granted to an SMCCCD student upon receipt and assessment of facts submitted in a completed Request for Medical Exemption form. **SMCCCD carefully reviews all requests for medical exemptions. Approval is not guaranteed.**

The District COVID-19 Health Officer will carefully review each request and determine approval. After the request has been reviewed and processed, you will be notified, in writing, if an exemption has been granted or denied. If the approved exemption contains a termination date, you will be expected to complete the vaccination prior to termination. Should the condition continue, or a new vaccination contraindication occur, a new request with updated documentation is required. Decisions are final and not subject to appeal. Individuals whose requests have been denied are permitted to reapply if new documentation and information should become available.

Medical exemption process:

- Read the [CDC COVID-19 Vaccine Information](#); _
- Complete and sign the following page of this form;
- Have your Licensed Health Care Provider (doctor) complete the provider section of this form;
- Submit the required completed documents.

Incomplete submissions will not be reviewed. Submit all forms and documentation together.

Completed request forms and all required documentation can be uploaded into the District's COVID-19 Vaccination Exemption Request Form link located at the Websmart Student Portal:

<https://phx-ban-ssb8.smccd.edu/>

SECTION 1: To Be Completed by Student

Please initial next to each of the statements below:

	I request exemption from the COVID-19 vaccination requirements due to my current medical condition . I understand and assume the risks of non-vaccination. I accept full responsibility for my health, thus removing liability from SMCCCD to the required vaccination.
	I understand that as I am not vaccinated, in order to protect my own health and the health of the community, I will comply with assigned COVID-19 testing requirements and other preventive requirements identified for unvaccinated individuals, including but not limited to wearing face coverings.
	I understand that in the event of an outbreak or threatened outbreak, I may be temporarily excluded from SMCCCD facilities and approved on-site activities. I agree to comply with these restrictions and accept responsibility for communicating with college staff as appropriate to allow compliance with health and safety requirements for unvaccinated individuals.
	Should I contract COVID-19, I will <u>immediately</u> report it to the COVID-19 Health Officer (CHO) and comply with all isolation and quarantine procedures specified by District/County procedures and remove myself from district property if so advised.
	I acknowledge that I have read the CDC COVID-19 Vaccine Information .
	I understand that this exemption will expire when the medical condition(s) contraindicating vaccination changes in a manner which permits vaccination, as determined by the District in reviewing the request.
	I understand and agree to comply with all District COVID-19 policies and procedures.
	I understand that this exemption is only valid while the District COVID-19 vaccination policy stands and I may need to submit a new request for any subsequent changes, new medical contraindications, or on expiration of an approved exemption. I further understand that the approval is provisional based on the current vaccination policy and is subject to change based on District requirements moving forward.
	I authorize my licensed health care provider (doctor) to provide SMCCCD with medical information about my medical exemption for the COVID-19 vaccination.
	I certify that the information I have provided in connection with this request is accurate and complete as of the date of this submission. I understand this exemption may be revoked and I may be subject to district disciplinary action if any of the information I provided in support of this exemption is false.

Printed Name: _____

Signature: _____ Date: _____

By checking this box and typing my name above, I understand and agree that I am submitting this document electronically and that it is the legal equivalent of having placed my handwritten signature on the submitted document.

SECTION 2: To be Completed by Health Care Provider

Attention Health Care Provider:

The San Mateo County Community College District (SMCCCD) policy requires that all students accessing on-site instruction and services receive a COVID-19 vaccination. _____ (insert patient's name) is requesting a medical exemption from this vaccination requirement. A medical exemption may be allowed for certain recognized contraindications.

Please certify the medical reason that your patient should not be vaccinated for COVID-19 by completing this form and attaching available supporting documentation. Information provided on this form will be reviewed in consideration of the exemption request.

CERTIFICATION

I certify that _____ (patient name) has the above contraindication and support the request for a medical exemption from the COVID-19 vaccine requirement at SMCCCD.

Explanation:

Provider Information

Medical Provider Name: _____

Medical Provider Specialty: _____

Signature: _____

Provider License Number: _____

Date: _____

Name of Provider Company: _____

Address: _____

Email: _____

Phone number: _____