REQUEST FOR MEDICAL EXEMPTION OR ACCOMMODATION
COVID-19 VACCINATION

Please

1. Complete the first section of this form, print it out and sign it.
2. Ask your medical provider (licensed M.D., D.O., P.A. or N.P.) to complete and sign the second section.
3. Scan the completed form to create a PDF.
4. Upload this form through the PyraMED health portal. (Follow the instructions at deanza.edu/return-to-campus/vax-exemption)

De Anza College and the Foothill-De Anza Community College District are committed to providing equal educational opportunities without regard to any protected status, and an academic environment that is free of unlawful harassment, discrimination and retaliation. The college and district are committed to complying with all laws protecting students' and employees' medical conditions or religious beliefs and practices.

When requested, the college and district will provide an exemption or reasonable accommodation for an individual's medical condition or religious beliefs and practices which prohibit the individual from receiving a COVID-19 vaccine, provided the requested accommodation is reasonable and does not create an undue hardship for the college or district, and provided that it does not pose a direct threat to the health or safety of the requesting individual or of others in the campus community.

In considering this request, the college or district may need to obtain additional information or documentation, and may need to discuss the nature of your medical condition with your medical provider. This information will be used by the appropriate college or district personnel to engage in an interactive process to determine eligibility for, and to identify, possible ADA accommodations.

By submitting this request, you are asserting that the information is complete and accurate to the best of your knowledge, and that you understand intentional misrepresentation may result in disciplinary action.

Section 1: Information from the Student or Employee Requesting the Exemption

_____
(First name)

_____
(Last name)

_____

(Campuswide ID – your eight-digit CWID)

_____

(Mailing address)

_____

(Email address)

_____

(Phone number)

I am requesting an exemption from the requirement for COVID-19 vaccination on the following medical grounds. (Please briefly explain the medical reason for your request; your medical provider – licensed M.D., D.O., P.A. or N.P. – will need to verify this below.)

I understand that if I receive an exemption, I may be subject to certain conditions for coming to campus. I also understand that my request for an accommodation may not be granted if it is not reasonable, if it poses a direct threat to the health or safety of others or to me, or if it creates an undue hardship on De Anza College or the Foothill-De Anza Community College District.

If I do qualify for a medical exemption, I understand that I will be required to comply with the following conditions

- If I test positive for COVID-19, I will stay at home for five days, except for medical treatment, and then take a new test.
    - If the new test is positive or I continue to have symptoms, I will stay at home for at least another five days
    - If the new test is negative, I can return to class but must wear a face mask for an additional five days
- If I am exposed to someone with COVID-19, but I do not have symptoms, I will get tested for COVID-19 between three to five days after the exposure
- If there is an outbreak of COVID-19 on campus, I may be asked to leave temporarily for my safety or the safety of others.
- I am responsible for any financial or academic burdens that may result from the above conditions.

I understand that if I decide to be vaccinated in the future, I should discuss the risks and benefits with my medical provider.

_____

(Student or employee signature)

(Date)

(Parent or guardian's signature, if student or employee is under 18)

(Parent or guardian's name, if student or employee is under 18)

(Date)

Section 2: Information from the Medical Provider (licensed M.D., D.O., P.A. or N.P.) for the Person Requesting the Exemption

I hereby certify that the above-named individual has a medical condition that contraindicates use of a COVID-19 vaccine.

The following conditions apply: (please check one)

- ○ There is an applicable CDC contraindication to the vaccine.
- ○ There is an applicable manufacturer's insert contraindication to the vaccine.
- ○ This individual has a physical condition or medical circumstance such that vaccination is not considered safe.

I would describe the relevant contraindication, physical condition or medical circumstance as follows:

The contraindication, physical condition or medical circumstance referenced above is:

- ○ Permanent
- ○ Temporary

If temporary, the date when this condition is expected to end is:

I recommend the following ADA accommodations to address this person's medically necessary exemption to COVID-19 requirements enacted by the college, county or state:

(Medical provider's name)

(Medical license number)

(State or country that issued the medical license)

(Signature)

(Date)

(Address of medical practice)

(Phone number of medical practice)

(Email address for medical practice)

Section 3: College Reviewer's Notes

On what date was this request received?

Was the exemption granted?

- ○ Yes
- ○ No

What accommodations or alternative conditions were imposed?

If exemption was not granted, what is the reason?

(Date of decision)

(Name of reviewer)

(Signature)