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 within the past 90 days (date of diagnosis: _____), 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 meeting criteria d above:**

_____

_____

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: _____

Part C: Request for Deferral of All COVID-19 Vaccines Based on Current Pregnancy

COVID-19 vaccination is recommended during pregnancy due to the increased risk of severe COVID-19 during pregnancy, and increased risk of preterm birth and other adverse pregnancy outcomes.

☐ I certify that the patient listed above is currently pregnant.

Estimated Due Date: _____

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 to the "Downloadable Forms" page on your patient portal.