Los Rios Community College District Student
COVID-19 Vaccination Medical Exemption Request Form

Consistent with the District's Operational Protocol, the COVID-19 vaccine is required for District students accessing on-ground classes, services, activities, and facilities. If you have a specific medical condition that precludes you from taking the COVID-19 vaccination and you seek a medical exemption from the District's COVID-19 vaccination requirement, please consult with your physician and complete this form.

This Section to be Completed by the Student

Please provide the following information:

Name: _____ Student ID: _____

E-mail: _____ Phone No.: _____

College_____

Physician's Name: _____ Physician's Phone No.: _____

Student Verification

I verify that the information I am submitting in support of my request for an exemption is complete and accurate to the best of my knowledge, and I understand that any intentional misrepresentation contained in this request will result in disciplinary action.

I understand that the information provided may be used by the District to help determine eligibility for and to identify possible reasonable modifications or accommodations. I understand that if I refuse to provide the information requested, my refusal may impact the District's ability to adequately understand my request or effectively identify possible reasonable modifications or accommodations.

I also understand that my request for a modification or accommodation may not be granted if the modification or accommodation would result in a fundamental alteration of the academic program, impose an undue financial or administrative burden on the College, or would result in a significant risk or direct threat to the health & safety of others.

Student Signature: _____ Date: _____

Print Name: _____

This Section to be Completed by the Medical Provider

Medical Provider Name: _____

Medical Provider Phone Number: _____

Medical Provider Address: _____

Medical Provider License Number: _____

Los Rios Student/Patient Name: _____

To Medical Provider: The Los Rios Community College District requires students to be fully vaccinated against COVID-19. This form is to certify whether the District student named above has

- a contraindication or precaution to COVID-19 vaccination recognized by the Centers for Disease Control and Prevention ("CDC") or by the vaccines' manufacturers; ***or***
- a COVID-19-related diagnosis or treatment within the last 90 days recognized by the CDC as a contraindication or precaution to the available COVID-19 vaccinations; ***or***
- a disability within the meaning of Title II of the Americans with Disabilities Act ("ADA") and Section 504 of the Rehabilitation Act that substantially limits the student's ability to be fully vaccinated against COVID-19.

Please only answer the specific questions asked below and do not provide any additional information. Do not provide any information regarding diagnosis, medical cause, or medical history. Your responses should be limited to your determination of the student's limitations or need for accommodations, if any. Further, the Genetic Information Nondiscrimination Act of 2008 ("GINA") prohibits employers from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. Therefore, we also request that you not provide genetic information when responding to this request.

Section A: Disability Related Questions

1. Does the student have an underlying medical condition that limits the student from being fully vaccinated against COVID-19 using any of the currently available COVID-19 vaccines? DO NOT SPECIFY THE CONDITION.

   Yes ___ No ___

2. If your answer to question one is "Yes," is the medical condition a physical or mental impairment that substantially limits the student's ability to engage in a major life activity, such as the ability to work, care for themselves, perform manual tasks, walk, see, hear, eat, sleep, or engage in social activities? An impairment substantially interferes with the accomplishment of a major life activity when the individual's important life activities are restricted as to the conditions, manner, or duration under which the student can perform them and can be performed in comparison to most people.

   Yes ___ No ___

   Probable Duration of the Medical Condition: _____

<u>Section B</u>: Health or Medical Condition Related Questions

1. Does the student have a contraindication or precaution to COVID-19 vaccination recognized by the Centers for Disease Control and Prevention ("CDC") or by the vaccines' manufacturers?

   Yes ___ No ___

   Probable Duration of the Contraindication or Precaution: _____

2. Did the student receive a COVID-19-related diagnosis or treatment within the last 90 days that is recognized by the CDC as a contraindication or precaution to the available COVID-19 vaccinations?

   Yes ___ No ___

   Probable Duration of the Contraindication or Precaution: _____

_____ _____

Medical Provider Signature Date