The Preuss School
UC San Diego

Dr. Helen V. Griffith
Executive Director

MEDICAL EXEMPTION AND/OR DISABILITY EXCEPTION REQUEST FORM
Exception to SARS-CoV-2 (COVID-19) Vaccination Requirement

Student Name:	Date of Birth:
Student ID:	Parent Phone Number:

This form should be used for Preuss students to request an Exception to the COVID-19 vaccination requirement in the Preuss School UC San Diego's SARSCoV-2 Vaccination Program Policy based on (a) Medical Exemption due to a Contraindication or Precaution to COVID-19 vaccination recognized by the U.S. Centers for Disease Control and Prevention (CDC) or by the vaccines' manufacturers; (b) Medical Exemption due to COVID-19 diagnosis or treatment within the last 90 days; or (c) Disability.

Fill out Part A to request a Medical Exemption due to Contraindication or Precaution. Fill out Part B to request a Medical Exemption due to COVID-19 diagnosis or treatment within the last 90 days. Fill out Part C to request an Exception based on Disability. More than one section may be completed if applicable. Important: Do not identify any diagnosis, disability, or other medical information (other than COVID-19 diagnosis in Part B). That information is not required to process your request.

_____ Part A: Request for Medical Exemption Due to Contraindication or Precaution
The Contraindications or Precautions to COVID-19 vaccination recognized by the CDC or by the vaccines' manufacturers apply to me with respect to all available COVID-19 vaccines. For that reason, I am requesting an Exception to the COVID-19 vaccination requirement based on Medical Exemption. My request is supported by the attached certification from my child's health care provider. I understand that some local (city/county) public health departments have issued orders specifying that the certification must be signed by a physician, nurse practitioner, or other licensed medical professional practicing under the license of a physician.

_____ Part B: Request for Medical Exemption Due to COVID-19 Diagnosis or Treatment
My child has been diagnosed with or treated for COVID-19 within the last 90 days. For that reason, I am requesting an Exception to the COVID-19 vaccination requirement based on Medical Exemption. My request is supported by the attached certification from my health care provider. I understand that some local (city/county) public health departments have

issued orders specifying that the certification must be signed by a physician, nurse practitioner, or other licensed medical professional practicing under the license of a physician.

_____ Part C: Request for Exception Based on Disability
My child has a Disability and I am requesting an Exception to the COVID-19 vaccination requirement as a Disability accommodation. My request is supported by the attached certification from my health care provider. I understand that some local (city/county) public health departments have issued orders specifying that the certification must be signed by a physician, nurse practitioner, or other licensed medical professional practicing under the license of a physician. Please provide any additional information that you think may be helpful in processing your request. Again, do not identify your diagnosis, disability, or other medical information.

While my request is pending, I understand that my child must comply with the NonPharmaceutical 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 NonPharmaceutical 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 my child must comply with any additional Non-Pharmaceutical Interventions applicable to my circumstances or position, as required by my Location. If my request is granted, I understand that I will be required to comply with Non-Pharmaceutical Interventions specified by my Location as a condition of my Physical Presence at any University Location/Facility or Program. I verify the truth and accuracy of the statements in this request form.

Parent Signature: **Date:**
Date Received by Preuss:

CERTIFICATION FROM HEALTH CARE PROVIDER

The University of California requires that its employees and students be vaccinated against COVID-19 infection as a condition of accessing any University location, facility, or program in person. The University may grant Exceptions to this requirement based on (a) Medical Exemption due to a Contraindication or Precaution to COVID-19 vaccination recognized by the U.S. Centers for Disease Control and Prevention (CDC) or by the vaccines' manufacturers; (b) Medical Exemption due to COVID-19 diagnosis or treatment within the last 90 days; or (c) Disability, provided that the individual's request for such an Exception is supported by a certification from their qualified licensed health care provider.

Health Care Provider Name:	**License Type, #, and issuing stated:**
Full Name of Patient:	**Student Date of Birth:**
Student ID #:	**Health Care Provider Phone/Email:**
PHYSICIAN SUPERVISOR AND LICENSE # (FOR A PHYSICIAN ASSISTANT WORKING UNDER A PHYSICIAN'S LICENSE)	

Please complete Part A of this form if one or more of the Contraindications or Precautions to COVID-19 vaccination recognized by the CDC or the vaccines' manufacturers apply to this patient.
Please complete Part B if this patient has been diagnosed with or treated for COVID-19 within the last 90 days.
Please complete Part C if this patient has a Disability, as defined below, that makes COVID-19 vaccination inadvisable in your professional opinion. More than one section may be completed if applicable to this patient. Important: Do not identify the patient's diagnosis, disability, or other medical information (other than COVID-19 diagnosis in Part B) as this document will be returned to the Preuss School.

Part A: Contraindication or Precaution to COVID-19 Vaccination

I certify that one or more of the Contraindications or Precautions recognized by the CDC or by the vaccines' manufacturers for each of the currently available COVID19 vaccines applies to the patient listed above. For that reason, COVID-19 vaccination using any of the currently available COVID-19 vaccines is inadvisable for this patient in my professional opinion.

The Contraindication(s) and/or Precaution(s) is/are:

_____ Permanent
_____ Temporary

If temporary, the expected end date is:_____

Part B: COVID-19 Diagnosis or Treatment Within Last 90 Days

___ I certify that my patient has been diagnosed with or treated for COVID-19 within the last 90 days.

___ My patient's COVID-19 diagnosis or last day of treatment (whichever is later) was on the following date: _____

___ My patient is being actively treated for COVID-19. The expected end date of treatment is the following date: _____

Part C: Disability That Makes COVID-19 Vaccination Inadvisable

"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. "Disability" includes pregnancy, childbirth, or a related medical condition where reasonable accommodation is medically advisable.

_____ 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: _____

Signature of healthcare provider:
Date: