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COLLEGE OF MARIN

STUDENT ACCESSIBLITY SERVICES

COVID-19 Vaccination Medical Exemption Request (Students)

TO BE FILLED OUT BY YOUR PHYSICIAN

Dear Physician:

In order to promote a safe and healthy work and academic environment, College of Marin has set forth directives and policies regarding COVID-19 and COVID-19 vaccination status. A medical exemption from COVID-19 vaccination is allowed for certain recognized contraindications.

Please complete the following:

Patient/Student's Name: _____

The individual listed above should not be immunized for COVID-19 for the following reasons (Please check all that apply):

Allergy

☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a component of the COVID-19 vaccine

☐ Immediate allergic reaction of any severity to a previous dose or known (diagnosed) allergy to a component of the vaccine (Vaccine Ingredients: https://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html#Appendix-C)

Which ingredient caused an allergic reaction? _____

What was the reaction? _____

Which brand of the COVID-19 vaccine is contraindicated and why?

How long will the medical contraindication last? _____

Physical Condition/Medical Circumstance

Other Medical Limitation—Please provide this information in a separate narrative that describes the other medical limitation requiring an exemption.

PHYSICIAN CERTIFICATION

I certify that_____has the above contraindication and I recommend that they should not take the COVID-19 vaccine until_____.

Physician's Signature: _____ Date: _____

(Note: Signature Stamp Not Acceptable)

Physician Medical License No.: _____

Please submit this completed form to: Student Accessibility Services at **sas@marin.edu** or fax to 415.457.4791