Chaffey College

Summer and Fall 2022 COVID-19 Vaccination Exemption/Accommodation Request (Medical Condition)

If you have an allergy to the COVID-19 vaccine or a specific medical condition that precludes you from taking the COVID-19 vaccination and you seek an exemption/accommodation, please consult with your physician and complete this form.

The information provided herein will be kept confidential by Chaffey.

To be Filled out by the Student

Please provide the following information:

Name: _____ Student ID: _____

E-mail: _____ Phone No.: _____

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

Physician's Address: _____

_____

Student Verification

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

I understand that the information provided may be used by Chaffey 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 Chaffey'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: _____

To be Filled out by your Physician

Dear Physician:

In order to promote a safe and healthy work and academic environment, Chaffey Community College District has set forth directives and policies regarding COVID-19 and COVID-19 vaccination status. Having the COVID-19 vaccination is a condition of enrollment for in-person courses. The College will explore accommodations for students who cannot take any of the approved COVID-19 vaccines due to an allergy or medical condition.

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 he/she should not take the COVID-19 vaccine until _____.

Physician Signature: _____ Date: _____

(Note: Signature Stamp Not Acceptable)

Physician Medical License No.: _____

***Please submit this completed form to: melissa.moreno@chaffey.edu**