CONNECT ▸ ENGAGE ▸ SUCCEED

Ohlone College COVID-19 Student Vaccine Medical/Disability Exemption Request Form

Please complete this form and submit to studentservices@ohlone.edu.

Part A: To be completed by the student:

Student's full name:______________________Student ID:________________Date of birth: ________

Please note that the only medically indicated contraindication that Ohlone will accept include:

- Severe allergic reaction (anaphylaxis) after a previous dose of or to a component of the COVID-19 vaccine, including but not limited to Polyethylene Glycol (PEG)
- Immediate allergic reaction to a previous dose or diagnosed allergy to a component of the vaccine

Part B: To be completed by healthcare provider:

I,___________________________(name of licensed MD, DO, PA, NP) hereby certify that the above-named person has a medical condition that contraindicates his/her vaccination with **COVID-19 (SARS-CoV-2) vaccine**.

The specific nature of the medical condition or circumstances thatcontraindicate immunization with this vaccine are indicated below (**REQUIRED**):

Click or tap here to enter text.

Medical Provider Office Stamp Required

Signature of Provider:____________________________Date: _________

Medical License Number: ______________________________________

State/Country of Issue: _______________________________________

Part C: To be completed by Student Services

Date Received: ___________

Date Reviewed: ___________

☐ Approved
☐ Denied

______________________ Director of Student Health

____________________________ Vice President of Student Services

Updated: 12/1/2021