UC Berkeley **Camp/Internship Immunization Medical/Disability Exemption Request Form**

Minor Child's Full Name: _____ Date of Birth: _____

Request for Exception Based on Medical Exemption

The above-named person has a medical condition that contraindicates their vaccination with the following vaccine(s):

☐ **ALL** currently available COVID-19 (SARS-CoV-2) vaccines

Please check the appropriate box to indicate the reason for medical exemption request:

a) ☐ The applicable CDC contraindication or precaution to this/these vaccine(s), or
b) ☐ The applicable manufacturer's vaccine insert contraindication or precaution to this/these vaccine(s), or
c) ☐ A COVID-19 diagnosis within the past 90 days (date of diagnosis: _____)

The contraindication and/or precaution is: ☐ Permanent ☐ Temporary

If temporary, the expected end date is: _____

OR

Request for Exception from All COVID-19 Vaccines Based on Disability

"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. Providers are asked to carefully consider risk of severe COVID-19 disease.

☐ 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: _____

Parent/Guardian Information

☐ I certify that I am the parent or guardian of the minor child named above and I am requesting an exemption to the COVID-19 vaccine requirement.

Signature: _____

Printed Name: _____

Address: _____

Email: _____

I, _____ [Name of licensed MD, DO, PA, NP] have reviewed the University of California COVID-19 Vaccine Policy*, and hereby certify the above.

_____ _____

Signature of Licensed Healthcare Provider Date

Office Stamp
(REQUIRED)

_____ _____

Printed Name of Healthcare Provider / License No. MD/DO/PA/NP

*https://policy.ucop.edu/doc/5000695/SARS-CoV-2_Covid-19