VENTURA COUNTY COMMUNITY COLLEGE DISTRICT
STUDENT MEDICAL EXEMPTION REQUEST FORM

STUDENT NAME:	STUDENT ID:
EMAIL:	
BEST PHONE NUMBER TO REACH YOU AT:	CAMPUS:

This form should be used by Ventura County Community College District ("District") students to request an exemption to the COVID-19 vaccination requirement in the District's Board Policy 506 "COVID-19 Vaccine Requirement for Employees and Students" 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 or (b) Medical Exemption due to COVID-19 diagnosis or treatment within the last 90 days.

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. More than one section may be completed if applicable. Important: Do not identify any diagnosis, disability, or other medicalinformation (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 exemption to the COVID-19 vaccination requirement. 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 B: Request for Medical Exemption Due to COVID-19 Diagnosis or Treatment

☐ I have been diagnosed with or treated for COVID-19 within the last 90 days. For that reason, I am requesting an exemption to the COVID-19 vaccination requirement. 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 specifyingthat the certification must be signed by a physician, nurse practitioner, or other licensed medical professional practicing under the license of a physician***

While my request is pending, I understand that I must comply with the Non- Pharmaceutical Interventions (e.g., face coverings, regular asymptomatic testing)for unvaccinated or not fully vaccinated individuals as a condition of my Physical Presence at any District Location/Facility or Program. These required Non-Pharmaceutical Interventions are defined by local and state public health, environmental health and safety, occupational health, or infection prevention authorities, including. I also understand that I must comply with any additional Non-Pharmaceutical Interventions applicable to my circumstances or position, as required by local and state authorities. If my request is granted, I understand that I will be required to comply with Non-Pharmaceutical Interventions specified by local and state authorities as a condition of my Physical Presence at any District Location/Facility or Program.

I verify the truth and accuracy of the statements in this request form.

Student Signature:_____ Date:_____

Date Received by Campus: _____ By:_____