Dear Student,

Please have your health care provider complete this Medical Questionnaire form for a COVID- 19 Vaccination Medical Exemption request.

Student to Complete:

Name: _____

Campus: _____ Student ID: _____

Health Care Provider's Name: _____ License #: _____

Health Care Provider's Phone #: _____ Email #: _____

Students 's Health Care Provider to Complete:

TO: Student's Health Care Provider
RE: **Supplemental Medical Questionnaire Request: Personal Medical Provider**

Please allow this memorandum to serve as an introduction. San Bernardino Community College District is requiring that all students be fully vaccinated with a COVID-19 vaccine. In response to this requirement, your patient informed their college, that they are medically unable to receive the COVID-19 vaccines.

San Bernardino Community College District has implemented the following safety protocols for all of its students learning in its buildings / facilities: all locations are following current CDC guidelines for cleaning and disinfecting, high availability of sanitizers and personal protective equipment, face masks will continue to be required indoors for all employees regardless of vaccination status, appropriate distancing and barriers are provided in alignment with current Cal/OSHA and California Department of Public Health (CDPH) standards, as well as upgraded HVAC filtration.

In response to your patient's request for a vaccine exemption, we need your assistance to continue to evaluate their request.

To this end, and to support your patient's request for a COVID-19 related accommodation, please review and complete the attached supplemental medical questionnaire. The completed questionnaire can be returned to your patient. Please note that as part of this process, we are only seeking confirmation of their medical inability to be vaccinated, the duration of such and if they can be in the physical learning environment unvaccinated. Please do not provide any information pertaining to medical condition, diagnosis, or treatment. We are not requesting, nor can we receive, private or protected medical information on your patient.

Thank you for your assistance in this matter.

Enc.: Supplemental Medical Questionnaire Request – Vaccine Exemption

Patient's Name: _____

SUPPLEMENTAL MEDICAL QUESTIONNAIRE

I have reviewed the Supplemental Questionnaire Memorandum for the above-named patient and can provide the following clarification:

(Check boxes and insert text as appropriate)

1. Is your patient medically restricted from receiving the COVID-19 vaccines?
   - ☐ NO, my patient is not medically restricted from receiving the COVID-19 vaccines (please skip to the end of this questionnaire and sign and date)
   - ☐ YES, my patient is medically restricted from receiving the COVID-19 vaccines. Please explain:
     a. What is the duration of the restriction from being administered a COVID-19 vaccine?
        - ☐ PERMANENT, it is not medically expected that my patient will ever be able to receive a COVID-19 vaccine.
        - ☐ TEMPORARY, it is anticipated that my patient will be cleared to receive a COVID-19 vaccine on or about _____ (date)
        - ☐ UNKNOWN, I am unable to comment on my patient's ability to be administered a COVID-19 vaccine in the future.

2. **ADDITIONAL RESTRICTIONS / CLARIFICATIONS**: Please use the space below to include any additional information that you believe would be helpful to the interactive process for this student. **Please do not list any information pertaining to medical condition or diagnosis.**

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

Health Care Provider's Original Signature Date

_____ _____

Health Care Provider's Name Printed License Number

RETURN A COPY OF THIS FORM TO YOUR PATIENT

THIS FORM MUST BE SUBMITTED TTRHOUGH COVID CLINIC PORTAL BY THE STUDENT.