



Glendale Community College  
**Student Immunization Medical/Disability Exemption Request Form**

Student's Full Name: \_\_\_\_\_

Student ID#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
*Electronic signatures will not be accepted*

**ALL INFORMATION BELOW IS TO BE FILLED OUT BY THE STUDENT'S LICENSED HEALTHCARE PROVIDER.**  
 See [www.glendale.edu/vaccinationmandate](http://www.glendale.edu/vaccinationmandate) for a list of licensed healthcare providers authorized to complete this form

**To Medical Provider:** The Glendale Community College District requires students to be fully vaccinated against COVID-19. This form is to certify whether the District student named above has

- a contraindication or precaution to COVID-19 vaccination recognized by the Centers for Disease Control and Prevention ("CDC") or by the vaccines' manufacturers; *or*
- a COVID-19-related diagnosis or treatment within the last 90 days recognized by the CDC as a contraindication *or* precaution to the available COVID-19 vaccinations; *or*
- a disability within the meaning of Title II of the Americans with Disabilities Act ("ADA") and Section 504 of the Rehabilitation Act that substantially limits the student's ability to be fully vaccinated against COVID-19.

Please only answer the specific questions asked below and do not provide any additional information. Do not provide any information regarding diagnosis, medical cause, or medical history. Your responses should be limited to your determination of the student's limitations or need for accommodations, if any. Further, the Genetic Information Nondiscrimination Act of 2008 ("GINA") prohibits employers from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. Therefore, we also request that you not provide genetic information when responding to this request.

**Section A: Disability Related Questions**

1. Does the student have an underlying medical condition that limits the student from being fully vaccinated against COVID-19 using any of the currently available COVID-19 vaccines? DO NOT SPECIFY THE CONDITION.  
 Yes \_\_\_ No \_\_\_
  2. If your answer to question one is "Yes," is the medical condition a physical or mental impairment that substantially limits the student's ability to engage in a major life activity, such as the ability to work, care for themselves, perform manual tasks, walk, see, hear, eat, sleep, or engage in social activities? An impairment substantially interferes with the accomplishment of a major life activity when the individual's important life activities are restricted as to the conditions, manner, or duration under which the student can perform them y can be performed in comparison to most people.  
 Yes \_\_\_ No \_\_\_
- Probable Duration of the Medical Condition:  
 \_\_\_\_\_

**Section B: Health or Medical Condition Related Questions**

1. Does the student have a contraindication or precaution to COVID-19 vaccination recognized by the Centers for Disease Control and Prevention ("CDC") or by the vaccines' manufacturers?  
 Yes \_\_\_ No \_\_\_

Probable Duration of the Contraindication or Precaution:  
 \_\_\_\_\_

2. Did the student receive a COVID-19-related diagnosis or treatment within the last 90 days that is recognized by the CDC as a contraindication or precaution to the available COVID-19 vaccinations?  
 Yes \_\_\_ No \_\_\_

Probable Duration of the Contraindication or Precaution:  
 \_\_\_\_\_

I, \_\_\_\_\_ [Name of licensed MD, DO, PA, NP] have reviewed the Glendale Community College Immunization Exemption Policy, and hereby certify the above.

\_\_\_\_\_  
 Signature of Licensed Healthcare Provider  
*Electronic signatures will not be accepted*

Circle one: MD / DO / PA / NP

\_\_\_\_\_  
 Printed Name of Healthcare Provider

\_\_\_\_\_  
 License No.

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Licensed Healthcare Provider Office Address

Office Stamp  
(REQUIRED)