RANCHO SANTIAGO
Community College District

Building the future through quality education

2323 North Broadway • Santa Ana, CA 92706 -1640 • (714) 480-7300 • www.rsccd.edu

Santa Ana College • Santiago Canyon College

The Rancho Santiago Community College District (the "District") has set forth a mandated vaccination program for all employees. _____ (insert Patient/Employee's Name) is requesting a medical exemption from this vaccination requirement. A medical exemption from COVID-19 vaccination may be allowed for certain recognized contraindications.

Please certify below the medical reason that your patient should not be vaccinated for COVID-19 by completing this form and attaching available supporting documentation.

The individual listed above should not be immunized for COVID-19 for the following reasons (Please check all that apply):

Allergy

☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a component of the COVID-19 vaccine.

☐ Immediate allergic reaction of any severity to a previous dose or known (diagnosed) allergy to a component of the vaccine (Vaccine Ingredients: https://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html#Appendix-C)

Which ingredient caused an allergic reaction?

What was the reaction?

Which brand of the COVID-19 vaccine is contraindicated and why?

How long will the medical contraindication last?

Physical Condition/Medical Circumstance

The physical condition of the patient or medical circumstances relating to the individual are such that vaccination is not considered safe. Please state, with sufficient detail for independent medical review, the specific nature and probable duration of the medical condition or circumstances that contraindicate vaccination with the COVID-19 vaccine.

Explanation:

Form is to be submitted to Human Resources at the following link:
https://dynamicforms.ngwebsolutions.com/Account/Login?ReturnUrl=%2FSubmit%2FPage%3Fform%3Dc3ff12ea-80ca-4015-a20c-c7fedfe47bf4%26page%3D315041%26token%3DX05Q1cxylhlxZ32CALj8-MgKd6N272nBfd-GSt8agVE

PHYSICIAN CERTIFICATION

I certify that _____ has the above contraindication and

I recommend that my patient should not take the COVID-19 vaccine until _____.

Physician Name: _____

Physician Signature: _____ Date: _____

(Note: Signature Stamp Not Acceptable)

Physician Medical License No.: _____

Physician Office Phone Number: _____

Medical Facility Name and Address (worksite):