

[School District Letterhead]

COVID-19 Vaccination Policy – Medical Accommodation Request

This form is for employees requesting a medical accommodation to requirements in the Mandatory COVID-19 Vaccination Policy. To request a medical accommodation, this form must be completed in full and returned to *[insert identity/title of school administrator]*. This form will be evaluated by school officials including the school district's School Nurse. The School District will contact you when a determination is made or if additional information or clarification is needed to further evaluate this request.

Data Privacy Notice: The School District is collecting the requested information to determine whether you may be provided another means of safely accessing School District property in lieu of the requirements in the School District's COVID-19 Vaccination Policy. You are not required to provide the requested information; however, if you do not provide the requested information, your request for an accommodation from the Policy cannot be processed and you must continue to abide by the requirements in the Policy. If you provide the information requested on this form, it will be reviewed by school officials whose input is necessary in order to consider the request and school officials who have a legitimate educational interest in the data.

Name: _____ Position: _____

Date of Birth: ____/____/____ School: _____

Supervisor: _____

1. Specify from which requirement(s) of the Policy you are requesting an accommodation:

2. What is the medical condition that prevents you from following the requirement(s)?

3. Is the medical condition permanent? If not, what is the expected duration of the medical condition impacting your ability to follow the requirements of the Policy?

4. Are there specific activities that impact your ability to wear a mask during the school day or at school events? If so, what are those activities?

By signing below, I hereby certify that the above statements and all information provided in connection with this COVID-19 Vaccination Policy Medical Accommodation Request are true and accurate. I further certify that I have read and understand the above Data Privacy Notice. I understand that the accommodation requested above may not be granted. I also understand that the School District may need to obtain additional information or clarification to further evaluate my request.

Signature: _____ Date: _____

Contact Information: (Phone) _____ (Email) _____