ANNE ARUNDEL COMMUNITY COLLEGE
101 College Parkway | Arnold, Maryland 21012-1895 | 410-777-AACC (2222) | www.aacc.edu

Medical Certification for Request for Accommodation from COVID-19 Vaccination and Testing

To be completed by medical provider for the following individual:

Student Name: _____

Dear Medical Provider,

Anne Arundel Community College ("College") requires vaccination against COVID-19 with a vaccine fully approved or approved for emergency use authorization by the Food & Drug Administration or by the government of a foreign country where the vaccine was administered ("COVID-19 vaccine") or testing for COVID-19 ("COVID-19 testing") for students who physically come to the College campus. The individual named above, a College Student ("Student"), is seeking an accommodation from this protocol due to a disability or medical reasons. If, in your medical opinion, you believe that the Student should not receive a COVID-19 vaccination and should not be tested for COVID-19, please complete this form to assist College in the reasonable accommodation process.

Vaccination:

The Student should not be immunized for COVID-19 for the following reasons (please check all that apply):

☐ The Student has a history of previous allergic reaction to indicate an immediate hypersensitivity reaction to a component of the vaccine.

Please indicate the type of prior allergic reaction, the component of the vaccine at issue, and the reason it indicates a hypersensitivity to a component of the vaccine.

Date of diagnosis of allergy: _____

☐ The Student's physical condition or medical circumstances are such that immunization is not considered safe.

Please indicate the specific nature and probable duration of the medical condition or circumstances that contraindicate immunization with the COVID-19 vaccine in the box below.

Date of diagnosis of medical condition: _____

☐ Other

Please provide a narrative that describes the reasons the Student needs an accommodation from the COVID-19 vaccine option.

Date of diagnosis of medical condition: _____

State which brand(s) of the COVID-19 vaccine is contraindicated:
___ Johnson & Johnson
___ Moderna
___ Pfizer
___ Other (please indicate the name of the vaccine that is contraindicated) _____

Testing:

The Student should not be tested for COVID-19 for the following reasons (please check all that apply):

☐ The Student's physical condition or medical circumstances are such that testing is not considered safe.

Please indicate the specific nature and probable duration of the medical condition or circumstances that contraindicate testing for COVID-19 in the box below, including whether the Student could be tested using certain testing techniques but not others (*e.g.*, nasal swab, saliva, etc.).

Date of diagnosis of medical condition: _____

☐ Other

Please provide a narrative that describes the reasons the Student needs an accommodation from the COVID-19 testing option in the box below.

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Date of diagnosis of medical condition: _____

Accommodation Request:

Please state the accommodation that is being requested.

Please state the length of time for which this accommodation is requested for the Student.

I certify that the Student has the above referenced medical conditions and request accommodation from both COVID-19 vaccination and testing for the Student.

Medical Provider Name (print):_____

Medical Provider Signature:_____ Date: _____

Medical Practice Name and Address: _____
_____

Practice Telephone: _____