Los Angeles Unified School District
Office of the Medical Director

Student Medical Exemption to COVID-19 Vaccine
Licensed Physicians (MD or DO only)

STUDENT NAME (Last, First, Middle):		BIRTHDATE:	
SCHOOL NAME	SCHOOL YEAR:	GRADE:	GENDER:

Exemption Due to Physical Condition or Medical Circumstance

I understand that due to the pandemic, combined with any additional personal risk factors *(school exposure, comorbidities, congregate or group living status, etc.)* the child may be at increased risk of acquiring COVID-19 with the potential for severe and fatal consequences. I have reviewed information about this vaccine and discussed with my medical professional the risks and benefits of my child not being vaccinated.

I understand that, whenever the District has good cause to believe that a pupil who is not completely immunized against a particular communicable disease may have been exposed to that disease, the District shall immediately inform the local health officer. The local health officer shall determine whether the pupil is at risk of developing or transmitting the disease and, if so, may require the exclusion of the pupil from that school until the completion of the incubation period or, if infection is suspected or occurs, until completion of the period in which the disease is communicable.

Vaccine	Duration of physical condition or medical circumstance	
COVID-19	☐ Temporary until date:_____	☐ Permanent

Indicate the specific nature and probable duration of the medical condition or circumstances, that student shall be exempt from the requirements of the COVID-19 immunization:

_____

_____

_____

_____

_____

Licensed physician's name, address, and telephone number:

Signature:_____**MD/DO**

License Number: _____

Date: _____

Parent/Guardian Consent for Release of Information

I, (parent/guardian name)_____ authorize (physician name) _____ to provide the Ocean Charter School with information contained in my child's medical record, including, but not limited to records supporting this request.

Parent Signature: _____ **Date:** _____

Reviewed By _____ _____ _____

Nurse/Physician(Print) **Nurse/Physician Signature** **Date**