



VACCINE PROCLAMATION MEDICAL QUESTIONNAIRE

Student Information (Student to Complete)

- Name:
- ctcLink ID:

Medical Exemption Information (Health Care Provider to Complete)

A student at Cascadia College has disclosed they have a medical condition or disability, which may prevent them from receiving an authorized COVID-19 vaccine. We are requesting you complete the following form for verification.

1. Are you a health care or rehabilitation professional?

2. What is your area of practice and/or medical expertise?

3. The student has disclosed they have a medical condition that may prevent them from receiving an authorized COVID-19 vaccine. Please identify the condition and verify that the medical condition prevents them from receiving an authorized COVID-19 vaccine.

4. What is the anticipated duration of the medical condition or disability, which prevents the student from receiving an authorized COVID-19 vaccination?

Certification & Signature

I have discussed the benefits and risks of immunizations with the student or parent/legal guardian and I certify that I am a qualified and licensed MD, ND, DO, ARNP, or PA, and declare that, in my professional opinion, the above responses are true and accurate to the best of my knowledge and ability.

- Health Care Provider Signature:
- Date:

Please return this form and your response to covidvaxexemption@cascadia.edu. We would very much appreciate your cooperation by completing your response no later than **October 18, 2021**.