Friends' Central School

Request for Medical Exemption from COVID-19 Vaccination

The health, safety and well-being of our Friends' Central School (FCS) community is a top priority. By the start of the 2022-23 school year, all students eligible for the COVID-19 vaccine must be fully up to date with their Covid vaccination(s) or must have been granted a medical or religious exemption in order to be on-site at Friends' Central School or to attend any FCS events on-site or off-site. We believe this is the most prudent position to take in order to meet our obligation to provide as safe a school community as possible. Exemptions and accommodations for medical and religious reasons will be made in accordance with applicable laws.

To request a medical exemption from the required COVID-19 vaccination, please complete the below section and have the student's medical provider complete the Medical Certification on page 2. The completed form should be returned to Health Services by email at exemptions@friendscentral.org or dropped off at the Nurse's Office at the FCS campus your child attends **no later than August 22, 2022**. Upon receipt of the completed form a meeting will be scheduled to discuss your request.

Student's name:
Current grade
Name of parent/guardian/caregiver completing this form
Preferred email address:
Preferred phone number:

If an exemption is granted, the School will make efforts to reasonably accommodate the individual while maintaining a safe environment for school community members, visitors, and others. Reasonable accommodations may include additional infection prevention and control measures, among other things.

- I request exemption from the COVID-19 vaccination requirement due to the above named student's current medical condition. I understand and assume the risks of non-vaccination. I accept full responsibility for the above named student's health, thus removing liability from Friends' Central School with respect to the required vaccination.
- I understand that as the above named student is not vaccinated, in order to protect the student's health and the health of the FCS community, I will comply with any assigned COVID-19 testing requirements and other preventive guidance.
- Should the above named student contract COVID-19, I will immediately report it to Health Services by email at healthservices@friendscentral.org and comply with all isolation and quarantine procedures specified by FCS.
- I certify that the information I have provided is true, accurate and complete to the best of my knowledge. I understand that any falsified information can lead to termination of the enrollment contract. I further understand that Friends' Central School is not required to provide this exemption

if doing so would pose a direct threat to the health and safety of the above named student or others in the school community or would create an undue hardship for Friends' Central School.

____ _______________

Parent/guardian/caregiver signature Date

Friends' Central School

Medical Certification for COVID-19 Vaccination Exemption

Student Name: ____

Dear Medical Provider,

Friends' Central School (FCS) requires all eligible students to be fully up to date with Covid vaccinations in order to be on-site at Friends' Central School or to attend any FCS events on-site or off-site. The above named student is seeking an exemption from this requirement. A medical exemption may be granted for certain recognized contraindications.

Please certify below the medical reason that your patient should not receive the COVID-19 vaccination by completing this and attaching any available supporting documentation. The completed form should be returned to your patient or directly to FCS Health Services by email at exemptions@friendscentral.org.

The person named above should not receive the COVID-19 vaccine due to:

____

____

This exemption should be:

☐ Temporary, expiring on: _______________ (Date), or _________________________________

☐ Permanent

I certify the above information to be true and accurate, and support the request for exemption from the COVID-19 vaccination for the above-named individual.

____

Medical Provider Name (print) Date

____

Medical Provider Signature

____

Practice Name & Address

Provider Phone Number