

**Granada Hills Charter
Student Medical Exemption to COVID-19 Vaccine
California Licensed Physicians (MD or DO only)**

Digital Signatures shall NOT be Accepted - Submit the Form to ghccovidmedexemption@ghctk12.com

To be Completed by the Parent:

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

To be Completed by the California Licensed Physician:

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 GHC 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, GHC 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.

Exemptions that are approved will only be granted for the current academic school year. You must reapply for a future exemption.

Indicate the specific nature of the physical condition or medical circumstances of the child for which a licensed physician does not recommend immunization. *I understand that, for the protection of the child and other students, the child may be excluded from attending school for prolonged periods during outbreaks or exposure to disease for which immunization has not been completed (17 CCR §6060):*

How long has this patient been under your care?

California Licensed Physician's Name (print) _____

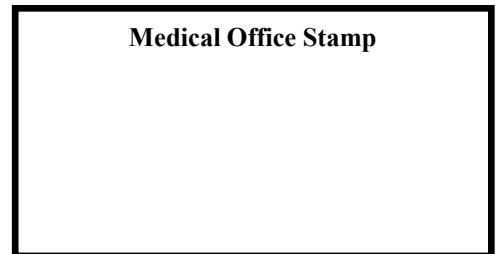
CA License Number: _____

Circle One: **MD / DO** Date of Signature: _____

Office Address: _____

Phone number: (____) _____

Physician's Physical Signature: _____



To be Completed by the Parent:

Parent/Guardian Consent for Release of Information

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

Parent/Guardian Physical Signature: _____ Date: _____