Deneen Guss. Ed.D
County Superintendent of Schools

COVID-19 Vaccination Medical Condition/Sincerely Held Religious Beliefs Exemption
Head Start

To comply with California Department of Public Health (CDPH), CalOSHA Safety and Health Standards, and the Head Start Program Performance Standards (HSPPS) employers are required to verify and document the vaccination status of employees. However, if an employee has a qualified medical condition or sincerely held religious beliefs exemption to the COVID-19 vaccination, this form must be completed by the employee and turned in to the employer. Employees with an approved exemption on file are nonetheless required to undergo diagnostic COVID-19 testing utilizing an MCOE testing location as feasible. Verification of weekly testing must be submitted to the employee's supervisor each week.

First Name _____ Last Name _____ Employee ID _____

Department/Program _____ Job Title _____

Exemption Type: ☐ Medical ☐ Sincerely Held Religious Beliefs

I certify that the information below is true and correct.

Employee Signature _____ Date _____

For Sincerely Held Religious Beliefs Exemption Only

☐ I am declining the COVID-19 vaccination based on sincerely held religious beliefs.

For Medical Condition Exemption Only

I am a physician, nurse practitioner, or other licensed medical professional authorized to practice medicine in a jurisdiction of the United States. By signing below, I affirm that I am the healthcare provider for the above named employee and they have a qualified medical reason to not receive the COVID-19 vaccination at this time.

Employee Exemption Length: ☐ Permanent ☐ Temporary through: _____

Clinical reason(s) for contraindication: _____

COVID-19 vaccinations that are clinically contraindicated: ☐ Pfizer-BioNTech ☐ Moderna ☐ Johnson & Johnson/Janssen

Healthcare Provider First Name _____ Healthcare Provider Last Name _____ Speciality _____

NPI Number _____ License Number _____ State of Licensure _____

Phone Number _____ Work Email Address _____

Address _____ City _____ State _____ Zip Code _____

Healthcare Provider Signature _____ Date _____