Medical Exemption Request From COVID-19 Vaccination

In accordance with the Los Angeles County Department of Public Health Officer Order, Children's Hospital Los Angeles (CHLA) is requiring all team members to receive the updated 2023-2024 seasonal COVID-19 vaccine and submit proof of vaccination.
Team members requesting an exemption due to a disability, recognized clinical contraindication(s) to COVID-19 vaccines, or a medical condition that requires a temporary delay in receiving COVID-19 vaccination must submit the below completed form to CHLA. Team members who tested positive for COVID-19 in the past 90 days may request a personal exemption through the Team Member Vaccination Registration form and do not need to complete this medical exemption request form.

When completing this form, do not disclose or provide any information related to disability, diagnosis, underlying medical condition, or genetic information.

Full Name: _____

Exemption: By signing below, I recommend that the individual identified above be exempted from CHLA's COVID-19 vaccination requirements based on:

☐ **Disability**
☐ **Recognized clinical contraindication(s) to COVID-19 vaccines**
☐ **Temporary delay (a temporary delay may be allowed if consistent with CDC recommendations due to clinical precautions and considerations)**

1) **Anticipated duration of inability to receive COVID-19 ☐ vaccine:** _____
(If duration is unknown or permanent, please indicate.)

2) **If the individual above is clinically contraindicated from receiving a COVID-19 vaccine, complete the following (check all that apply)**:
☐ Pfizer-BioNTech ☐ Moderna ☐ Novavax ☐ Other _____
for the following recognized clinical reason(s) for the contraindication(s):
_____
_____
_____
_____
_____

3) **If the individual above is temporarily delayed from receiving a COVID-19 vaccine, please identify (i) the clinical precautions and considerations and (ii) the date the individual may begin receiving doses of the COVID-19 vaccine:**
_____
_____
_____

Licensed Medical Practitioner Name: _____ MD, DO, PA or NP (please circle)
License #: _____
Telephone number: _____
Address: _____

By completing and signing this form, I certify that I am a licensed practitioner who is not the individual receiving the exemption, that I am acting within the scope of my practice and in accordance with my medical judgment and all applicable laws, and I hereby certify that the statements and information contained in this form are true, accurate, and complete.

Note, this form may be subject to review by the California Department of Public Health, the Centers for Medicare & Medicaid Services, or other applicable agencies.

Signature of Authorized Licensed Medical Practitioner: _____

Date: _____