

STUDENT MEDICAL QUESTIONNAIRE VACCINE PROCLAMATION
FORM PROCLAMATION 21-14 (VACCINE REQUIREMENT)

VACCINE PROCLAMATION MEDICAL QUESTIONNAIRE FORM

Notice: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. 29 CFR § 1635.8(b)(1)(i)(B).

PART 1 (completed by student)

Date:

Name of Health Care Provider:

Address of Health Care Provider

Name of Student:

Student ID No.:

The above named student is enrolled with Peninsula College.

The student has disclosed they have a medical condition or disability which may prevent them from receiving an authorized COVID-19 vaccine.

To assist Peninsula College to understand whether _____ has a medical condition or disability which prevents them from receiving an authorized COVID-19 vaccine, please complete the health care provider's questionnaire. A signed "Waiver and Authorization To Release Information" is included below.

PART 2: Waiver and Authorization To Release Information (completed by student)

I authorize Peninsula College to receive my medical information related to the Covid-19 high risk proclamation accommodation request. My medical information may be sent to **Peninsula College ATTN: Vice President for Student Services, 1502 E. Lauridsen Blvd., Port Angeles, WA 98362 via mail, email thaggerty@pencol.edu or fax 360-417-6581.**

Student Name _____

Student Address _____

Student Phone Number _____

Student Email _____

Date Waiver is Signed _____ Expiration Date of Authorization: _____

Student Signature _____

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PART 3: Health Care Provider Questionnaire (to be completed by health care provider)

1. Are you licensed to practice in the state of Washington?

YES

NO

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

3. The student has disclosed they have a medical condition or disability that may prevent them from receiving an authorized COVID-19 vaccine. Does this student suffer from such a condition?

YES NO

Student Name

4. Please identify the condition.

I, _____, declare that, in my professional opinion, the above responses are true and accurate, to the best of my knowledge and ability.

Signature

Date

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Return Instructions for the Health Care Provider

Peninsula College ATTN: Vice President for Student Services, 1502 E. Lauridsen Blvd., Port Angeles, WA 98363 or email thaggerty@pencol.edu or fax 360-417-6581. We would very much appreciate your cooperation by completing your response no later than **October 18, 2021**. To avoid delay, you may to electronically transmit your response to the following fax number: **(360) 417-6581**.

If you have any questions, please do not hesitate to contact Trisha Haggerty, Executive Assistant to the Vice President for Student Services at **(360) 417-6231**.

Check all that are attached: Waiver and Authorization To Release Information