COVID-19 Medical Exemption Form

Colorado Law C.R.S. § 25-4-902 requires all students attending school in the State of Colorado to be vaccinated against certain vaccine-preventable diseases (i.e. Measles, Mumps, Rubella) as established by Colorado Board of Health Rule 6 CCR 1009-2, unless an exemption is filled. While the Board of Health does not currently require vaccination against COVID-19, Otero College requires that students, as a condition of living in on-campus housing, participating on Otero College athletic teams, and/or participating in designated health sciences programs, be vaccinated against COVID-19 unless an exemption is filed.

If granted an exemption, students*:

- May be required to participate in weekly COVID-19 testing as directed by Otero College;
- Must monitor College email daily for important health notifications;
- Must isolate for a period of time as required by local health department regulations if they test positive for COVID-19; and may have to quarantine for a period of time per local health department regulations if determined a close contact.

**These requirements are subject to change based upon available and emerging epidemiological evidence and the overall burden of disease related to COVID-19 transmission on our campus and in our region.*

Student Information

Last name:	**First name:**	**Middle name:**
Date of Birth (mm/dd/yy):		

Parent/Guardian completing this form (Only if student is under 18 years old):

Last name:	**First name:**	**Middle name:**

Relationship to Student: ☐ Mother ☐ Father ☐ Legal Guardian

Vaccine Required for Students Living On-Campus, Athletics, and Designated Health Sciences Program:

Check vaccine declined:	List medical contraindication(s) for each vaccine declined:
☐ SARS0CoV-2 (COVID-19)	

Statement of Exemption The physical condition of the above named student is such that vaccination would endanger their life or health or is medically contraindicated due to other medical conditions. The information I have provided on this form is complete and accurate.

REQUIRED Signature: _____Date: _____
Physician (MD, DO), Advanced Practice Nurse (APN), or Physician (authorized pursuant to section 12-240-107 (6), C.R.S.)