



Learning Support Services (LSS) – LA 104
4800 East Huron River Drive
Ann Arbor, Michigan 48105

Tel: (734) 973-3342
Fax: (734) 477-8517
www.wccnet.edu

Medical Exemption Verification Form - COVID 19

The student named below has requested not to wear a face covering which is required for all persons while on campus or at WCC supported activities.

Student's Name:	_____		
	Last	First	MI
WCC ID Number:	@_____	Date of Birth:	_____
I authorize the release of the information requested below to Learning Support Services (LSS) at Washtenaw Community College.			
Student's Signature	_____		Date

To be completed by a licensed PROFESSIONAL:

1. Diagnosis/Medical Condition:

2. Date(s) of Diagnosis/Medical Condition:

3. How does not wearing a face covering reduce or alleviate current symptoms and better manage the student's medical condition?

4. Are there times when the student may be able to safely wear a face covering (include time frame, type of activity student may be doing, e.g. sitting in class, participating in lab activities, walking to parking lot, etc.)?

Please continue on second page

Student's Name: _____

5. Please identify times the student absolutely cannot wear a face covering, e.g. over 4 hours doing strenuous activity (please define the strenuous activity and timeframe), e.g. running with pulse rate above 145?

6. Are there alternative options to the recommended face covering?

7. Current prescribed medications related to medical condition (mitigating the effects of the condition and/or causing side effects related to student's educational functioning):

Medication	Dose/Frequency	Effects/Side Effects
_____	_____	_____
_____	_____	_____
_____	_____	_____

8. Date of the last appointment with the student? _____

9. How often does the student receive treatment? _____

In addition, I have the necessary professional qualifications to document my client/patient's medical condition, and the information provided on this form is accurate to the best of my knowledge.

Name of Professional (Please print): _____

Signature of Professional: _____

License #: _____

Date: _____

Address: _____

Phone and FAX: _____

Please complete this document and FAX the form our office at 734-477-8517 as soon as possible.

