NATIONAL SPEECH & DEBATE ASSOCIATION

MEDICAL ACCOMMODATION REQUEST

SECTION 1: ATTENDEE INFORMATION

NAME: .....

SCHOOL: .....

STATE: .....

EMAIL:.....

ROLE:

- ☐ **COACH**
- ☐ **STUDENT (AT LEAST 18 YEARS OF AGE)**
- ☐ **OTHER (PLEASE DESCRIBE):** .....
- ☐ **JUDGE**
- ☐ **STUDENT UNDER 18 YEARS OF AGE**

PLEASE NOTE: NSDA endorses the American Medical Association's position that non-medical exemptions for vaccinations endanger the unvaccinated individual and the community at large. Therefore, NSDA will waive the requirement for COVID-19 vaccination only for documented and legitimate medical exemptions. For religious exemptions, please use the **Religious Accommodation Request** form.

1. **Please provide the reason/condition for which you require a medical accommodation from the National Speech & Debate Association's vaccination policy.**

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2. **I understand that if granted, my request for an exception/accommodation to the vaccine mandate will be conditioned on the requirement to wear a mask, provide a negative COVID-19 PCR test administered between June 9-12 by June 12 at my own cost, social distance, and monitor symptoms daily.**

   ☐ **AGREE** ☐ **DISAGREE**

3. **Please provide any additional information you think may be relevant to this request (attach additional pages as necessary)**

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I understand that the National Speech & Debate Association is not required to provide any accommodation that would impose an undue hardship upon the organization. I further understand that if the accommodation is granted that it may be reviewed/revised /revoked in the future if business needs or circumstances change, or if any of the information on the accommodation request is found to be inaccurate. I consent to the redisclosure of this form and the information supplied to support it (including medical information) if needed to evaluate the request, or in order to comply with a legal requirement.

I have read and understand the Form and I agree to and accept its provisions. I affirm that I am at least 18 years of age, or, if I am under 18 years of age, I have obtained the required consent of my parents/legal guardians as evidenced by their signatures here. I Accept:

		MM/DD/YY
.....	.....	.....
NAME (PRINT)	SIGNATURE	DATE (MM/DD/YY)

If under 18, parent or legal guardian must sign. I am the parent/legal guardian of the person signing the Form and I hereby ratify it and release all claims whatsoever which either I or above student may have with respect to the matters covered by the Form.

		MM/DD/YY
.....	.....	.....
PARENT/GUARDIAN NAME (PRINT)	SIGNATURE OF PARENT/GUARDIAN	DATE (MM/DD/YY)

SECTION 2: HEALTHCARE PROVIDER INFORMATION

This section must be completed by a licensed physician (MD or DO), nurse practitioner (NP), or physician's assistant (PA).

I certify that I have provided medical care for the individual referenced in Section 1 of this document. I further certify that it is my fully formed opinion that this individual's risk of vaccination against COVID-19 outweighs the individual and community risk of morbidity and mortality from COVID-19 infection. I confirm that this opinion conforms with acceptable standards of practice.

		MM/DD/YY
.....	.....	.....
NAME (PRINT)	SIGNATURE	DATE (MM/DD/YY)

.....	.....
PLACE OF EMPLOYMENT	PHONE NUMBER