Medical Attestation
Information & Consent

First and Last Name: ____

Phone Number: ____

I, ____________________________________ (print name) hereby authorize my physician to release the information on this form, not later than December 1st, 2021 to Hicks Morley c/o Donna M. D'Andrea at donna-dandrea@hicksmorley.com, who is reviewing this form on behalf of the Georgian Peaks Club for the purpose of verifying my vaccination status and for the purpose of evaluating my request for accommodation on medical grounds.

I understand that I may revoke this authorization at any time.

I understand that the decision to grant or refuse an accommodation will be made on the basis of legal advice.

Signature: ____

Date (dd/mm/yy): _____________________________________

Treating Physician Attestation

The above individual is under my care. I attest that based on my knowledge of my patient and the information available to me, the above patient has a medical condition which prevents them from receiving a COVID-19 vaccine at this time.

The medical contraindication must meet the criteria below as per the National Advisory Committee on Immunization (NACI).

Please check the appropriate box:

☐ Pre-existing condition(s)

- Severe allergic reaction or anaphylaxis to a component of a COVID-19 vaccine
- Myocarditis prior to initiating an mRNA COVID-19 vaccine series (individuals aged 12-17 years old)

☐ Adverse Effects Following COVID-19 Immunization

- Severe allergic reaction or anaphylaxis following a COVID-19 vaccine
- Thrombosis with thrombocytopenia syndrome (TTS)/Vaccine-Induced Immune Thrombotic Thrombocytopenia (VITT) following the Astra Zeneca/COVISHIELD COVID-19 vaccine
- Myocarditis or Pericarditis following a mRNA COVID-19 vaccine
- Serious adverse event following immunization (e.g. results in hospitalization, persistent or significant disability/incapacity)

☐ Contraindications to Initiating a AstraZeneca/COVISHIELD COVID-19 Vaccine Series

- History of capillary leak syndrome (CLS)
- History of cerebral venous sinus thrombosis (CVST) with thrombocytopenia
- History of heparin-induced thrombocytopenia (HIT)
- History of major venous and/or arterial thrombosis with thrombocytopenia following any vaccine
- Serious adverse event following immunization (e.g. results in hospitalization, persistent or significant disability/incapacity

☐ Actively receiving monoclonal antibody therapy OR convalescent plasma therapy for treatment or prevention of COVID-19

☐ List details of any “other” reason the patient is unable to receive a COVID-19 vaccine, on the basis that the medical ground is enumerated in the *Human Rights Code*.

The patient’s medical condition is:

☐ Temporary. Should no longer be an issue, effective (date) __________________________

☐ Permanent

Physician’s Name: ____

Physician’s Signature: ____

Date: ____