**CONFIRMATION OF AN IMMUNOCOMRPROMISED CONDITION**

**PERSONAL IDENTIFICATION**

Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* **By checking this box, I confirm that the above-named student is** diagnosed with a medical condition of a severe nature which renders them immunocompromised\*, or who ­­­are taking medications resulting in immunosuppression, placing them at greater risk for a more serious COVID reaction. It is recommended that this student not participate in in-person learning at this time. \*For example (**please DO NOT disclose/circle if applicable**):
* a transplant recipient (including solid organ transplant and hematopoietic stem cell transplants)
* receiving stable, active treatment (chemotherapy, targeted therapies, immunotherapy) for a malignant hematologic disorder or solid tumour
* in receipt of chimeric antigen receptor (CAR)-T-cell
* an individual with moderate or severe primary immunodeficiency (for example, DiGeorge syndrome, Wiskott-Aldrich syndrome)
* Stage 3 or advanced untreated HIV infection and those with acquired immunodeficiency syndrome
* undergoing active treatment with the following categories of immunosuppressive therapies: anti-B cell therapies (monoclonal antibodies targeting CD19, CD20 and CD22),
* high-dose systemic corticosteroids,
* alkylating agents, antimetabolites, or tumour-necrosis factor (TNF) inhibitors
* and other biologic agents that are significantly immunosuppressive or are taking [specific immunosuppressant medications](https://www.health.gov.on.ca/en/pro/programs/publichealth/coronavirus/docs/vaccine/COVID-19_vaccine_third_dose_recommendations.pdf) (PDF)
* receiving dialysis (hemodialysis or peritoneal dialysis)

**Signature of accredited diagnosing health provider:**

 **Office Stamp and/or Letterhead (MANDATORY):**

|  |  |
| --- | --- |
| Name: Designation: Signature: Date: Telephone: Fax:  |  |

**STUDENT’S WRITTEN CONSENT TO SHARE INFORMATION**

**I hereby give consent for the information regarding my medical condition provided on this form to be released to authorized persons within the Trent University Student Accessibility Services for the purpose of establishing or reviewing academic accommodations.**

**I give consent for authorized persons within the Trent University Student Accessibility Services to contact the health professional listed on this form to discuss confidential information regarding my medical condition and accommodation needs.**

Student Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_