

Appendix A - Tech Trek Vaccination Policy

1. AAUW California Tech Trek will be in compliance with all federal, state, local, and campus-specific vaccination guidance and regulations for in-person events.
2. All in-person attendees must be vaccinated with Mumps, Measles, and Rubella (MMR) vaccines that are approved and recommended by the CDC, or submit a doctor-authorized medical exemption per Appendix A no later than two weeks prior to camp start date. Covid vaccinations are also required **but selected participants may affirmatively decline in writing via online camp registration system no later than two weeks before camp.**
 - a. Individuals are considered vaccinated for MMR according after having received 2 doses of an approved MMR vaccine at least 28 days apart.
 - b. Unvaccinated individuals aged 12 and above are considered vaccinated for COVID 19 (1) two weeks after receiving the second dose in a two-dose 2025-2026 COVID-19 Novavax vaccine series or (2) two weeks after receiving a single dose 2025-2026 COVID-19 Moderna or Pfizer bivalent vaccine.
 - c. Individuals previously vaccinated with any pre-2023 series should receive 1 dose of the 2025-2026 version of Pfizer, Novavax, or Moderna vaccines to be current or up to date.
3. Evidence of immunization or medical exemption/waiver must be submitted via the CampDoc online camp registration system following camper selection, no later than two weeks prior to camp start date. It is strongly recommended that affirmative declination be submitted at the same time.
4. Parents will be required to complete a waiver releasing AAUW from all liability associated with COVID, no later than two weeks prior to camp start date. The waiver will be provided for parent signature during the online registration process.
5. Masking may be required indoors by all attendees and staff except during meals or when properly socially distanced.
6. Social distancing will comply with current campus, city, county and state requirements.
7. If COVID symptoms develop at any time among campers or staff, rapid antigen testing will be done. If the camper or minor staff member tests positive, parents will be contacted for pick up as soon as possible. The affected individual will be isolated from the rest of the camp while waiting for parents to arrive. Adult staff members who test positive will be required to leave camp.

AMERICAN ASSOCIATION OF UNIVERSITY WOMEN TECH TREK

EXEMPTION MEDICAL AND/OR DISABILITY EXCEPTION REQUEST FORM

Exception to Mumps, Measles, and Rubella (MMR) and SARS-CoV-2 (COVID-19) Vaccination Requirement

CAMPER OR VOLUNTEER NAME	CAMPUS
VOLUNTEER ROLE (IF APPLICABLE)	PARENT NAME (IF MINOR)
PHONE NUMBER	PHONE NUMBER
EMAIL	EMAIL

This form should be used by American Association of University Women California (AAUW California) Tech Trek campers or volunteer staff to request a Medical Exemption and/or Disability Exception to the Mumps, Measles, and Rubella (MMR) and COVID-19 Primary Series vaccination requirements per AAUW California and CDC guidelines.

Those who are otherwise permitted by AAUW California policy and/or applicable public health directives to decline COVID-19 vaccinations should instead use the Affirmative Declination Statement form in the online registration system.

Fill out Part A to request a Medical Exemption due to Contraindication or Precaution. Fill out Part B to request an Exception based on Disability. More than one section may be completed if applicable. Do not identify any diagnosis, disability, or other medical information. That information is not required to process your request.

Your request must be supported by a health care provider’s certification, signed by a physician, nurse practitioner, or other licensed medical professional practicing under the license of a physician.

Part A: Request for Medical Exemption Due to Contraindication or Precaution

- I am requesting an Exception to the MMR and Covid 19 vaccination requirement based on Medical Exemption. The Contraindications or Precautions to MMR vaccination (recognized by the U.S. Centers for Disease Control and Prevention, the California Department of Public Health, or in the case of internationally administered vaccines, the World Health Organization) apply to me with respect to all available MMR Vaccines.

**AMERICAN ASSOCIATION OF UNIVERSITY WOMEN TECH TREK
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My request is supported by the attached certification from my health care provider. The certification must be signed by a physician, nurse practitioner, or other licensed medical professional practicing under the license of a physician.

Part B: Request for Exception Based on Disability

I have a Disability and am requesting an Exception to the MMR and/or COVID-19 vaccination requirement as a Disability accommodation. My request is supported by the attached certification from my health care provider.

Please provide any additional information that you think may be helpful in processing your request. ***Do not identify your diagnosis, disability, or other medical information.***

While my request is pending and if it is approved, I understand that I or my child must comply with Tech Trek’s Non-Pharmaceutical Intervention requirements (e.g., face coverings, regular asymptomatic testing) for individuals who are not up to date on MMR or COVID-19 vaccination as a condition of physical presence at any Tech Trek- sponsored location. I also understand that I or my child must comply with any additional Non-Pharmaceutical Interventions applicable to my/her position, as required by AAUW California and the campus.

I verify the truth and accuracy of the statements in this request form.

Volunteer or Minor's Parent Signature: _____ Date: _____

Submitted to AAUW: Date: _____ By: _____

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CERTIFICATION FROM HEALTH CARE PROVIDER

Your patient is a student or volunteer who has requested an Exception to AAUW’s MMR and COVID-19 vaccination requirement based on (a) Medical Exemption due to a Contraindication or Precaution; and/or (b) Disability. Your patient is seeking to support their request for such an Exception with a certification from their qualified licensed health care provider.

HEALTH CARE PROVIDER NAME	LICENSE TYPE, # AND ISSUING STATE
FULL NAME OF PATIENT	DATE OF BIRTH OF PATIENT
PATIENT’S ID NUMBER	HEALTH CARE PROVIDER PHONE/EMAIL
PHYSICIAN SUPERVISOR AND LICENSE # (FOR A PHYSICIAN ASSISTANT WORKING UNDER A PHYSICIAN’S LICENSE)	

Please note the following from the Genetic Information Nondiscrimination Act of 2008 (GINA), which applies to all student or volunteer participants:

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. “Genetic information,” as defined by GINA, includes an individual’s family medical history, the results of an individual’s or family member’s genetic tests, the fact that an individual or an individual’s family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual’s family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Please complete Part A of this form if one or more of the Contraindications or Precautions to MMR and/or COVID-19 vaccinations recognized by the U.S. Centers for Disease Control and Prevention (CDC), the California Department of Public Health (CDPH), or in the case of internationally administered vaccines, the World Health Organization (WHO), apply to this patient. Please complete Part B if this patient has a Disability, as defined below, that makes MMR and/or COVID-19 vaccination inadvisable in your professional opinion. More than one section may be completed if applicable to this patient.

Important: Do not identify the patient’s diagnosis, disability, or other medical information as this document will be returned to AAUW California.

Part A: Contraindication or Precaution to MMR and COVID-19 Vaccination

- Covid 19. I certify that one or more of the Contraindications or Precautions (recognized by the CDC, the CDPH, or in the case of internationally administered vaccines, the WHO) for each of the currently available Vaccines used for COVID-19 applies to the patient listed above. For that reason, vaccination using **any** of the currently available COVID-19 Vaccines is inadvisable for this

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patient in my professional opinion. The Contraindication(s) and/or Precaution(s) is/are: Permanent Temporary.

If temporary, the expected end date is: _____.

- Mumps, Measles, and Rubella (MMR). I certify that one or more of the Contraindications or Precautions (recognized by the CDC, the CDPH, or in the case of internationally administered vaccines, the WHO) for each of the currently available Vaccines used for MMR applies to the patient listed above. For that reason, vaccination using **any** of the currently available MMR Vaccines is inadvisable for this patient in my professional opinion. The Contraindication(s) and/or Precaution(s) is/are: Permanent Temporary.

If temporary, the expected end date is: _____.

Part B: Disability That Makes MMR and COVID-19 Vaccination Inadvisable

“Disability” is defined as a physical or mental disorder or condition that limits a major life activity and any other condition recognized as a disability under applicable law. “Disability” includes pregnancy, childbirth, or a related medical condition where reasonable accommodation is medically advisable.

- I certify that the patient listed above has a Disability, as defined above, that makes MMR vaccination inadvisable in my professional opinion. The patient’s disability is: Permanent Temporary.

If temporary, the expected end date is: _____.

- I certify that the patient listed above has a Disability, as defined above, that makes COVID-19 vaccination inadvisable in my professional opinion. The patient’s disability is: Permanent Temporary.

If temporary, the expected end date is: _____.

Signature of Health Care Provider