COVID-19 HIGH RISK
SELF ATTESTATION FORM

This form must be completed if you are between the ages of 16-64 and deemed to be at the very highest risk to get very sick from COVID-19 due to one or more of the qualifying severe health conditions (listed below)

- **Cancer**, *current with weakened immune system*
- **Chronic kidney disease**, *stage 4 or above*
- **Chronic pulmonary disease**, *oxygen dependent*
- **Down Syndrome**
- **Solid organ transplant**, *leading to a weakened immune system*
- **Pregnancy**
- **Sickle cell disease**
- **Heart conditions**, *such as heart failure, coronary artery disease, or cardiomyopathies (but not hypertension)*
- **Severe obesity** *(Body Mass Index ≥ 40 kg/m²)*
- **Type 2 Diabetes mellitus** *with hemoglobin A1c level greater than 7.5%*

OR

If as a result of a developmental or other severe high-risk disability, one or more of the following applies:

- I am likely to develop severe life-threatening illness or death from COVID-19 infection
- Acquiring COVID-19 will limit my ability to receive ongoing care or services vital to my well-being and survival
- Providing adequate and timely COVID care will be particularly challenging as a result of my disability

Dated:

I, ____ affirm/attest that I have one or more of the qualifying

☐ severe health conditions (from list above); or

☐ severe high-risk disability

By signing this form, I certify that the information provided is accurate and factual.

Printed Name: ___________________________

Signature: ______________________________