COVID-19 Vaccine Medical Exemption Request Form

Section I
To be completed by Student or Parent/Guardian (if student is under 18)

Last Name	First Name	Date of Birth

Section II
To be completed by Medical Provider

Medical Provider certification of contraindication: I certify that my patient (named above) should not be vaccinated against COVID-19 because they have one or more of the following contraindications:

1) Documented* anaphylactic allergic reaction or other severe adverse reaction to any COVID-19 vaccine, e.g., cardiovascular changes, respiratory distress, and/or history of treatment with epinephrine or other emergency medical attention to control symptoms. *Generally, this does not include gastrointestinal symptoms as the sole presentation of allergy*. ***Describe the specific reaction:***
   ____
   ____
   ____
   ____
   ____
   ____

2) Documented* allergy to a component of the vaccine; does not include sore arm/local reaction. ***Describe the specific reaction:***
   ____
   ____
   ____
   ____
   ____
   ____

Please include copies of relevant documentation

3) Other documented* contraindication. ***Please explain:***

____

____

____

____

____

____

____

Signature of Medical Provider

Name (Please Print):	Clinic Stamp/License:
Email:	Phone:

Once complete, student should upload this form and any supporting documentation via the Student Health Portal. Please note: medical exemption requests are not automatically approved. You will be notified via email whether your request has been granted or not. If you have not heard from Student Health Services within 2 weeks of having submitted this documentation, please call the office at 518.327.6319 to check on its status.