



State University of New York at Orange

COVID-19 Vaccination Requirement  
Medical Exemption Request Model Form

**Medical Exemption Request (to be completed by medical provider)**

A licensed medical provider (Physician, Physician's Assistant, or Nurse Practitioner) and student should review [the CDC guidance](#) regarding contraindications for COVID-19 vaccines. The provider must complete Section(s) A and/or B and provide their provider information in Section C.

**Section A. Medical Provider Certification of Contraindication:** I certify that my patient (named above) cannot be vaccinated against COVID-19 because of the following contraindication:

Please select which of the medically indicated COVID-19 vaccine contraindications defined by the CDC apply:

- ☐ Severe allergic reaction (anaphylaxis) after a previous dose or to a component of the COVID-19 Vaccine, including Polyethylene Glycol (PEG). (***Describe reaction/response below and contraindication to alternative vaccines.***)
- ☐ Immediate allergic reaction to previous dose or known (diagnosed) allergy to a component of the vaccine. (***Describe reaction/response below and contraindication to alternative vaccines.***)

Additional details on the selected option(s) above (to be completed by the medical provider):

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Please note that **NONE of the following are considered contraindications** to the COVID-19 vaccine.

- Local injection site reactions to previous COVID-19 vaccines (erythema, induration, pruritus, pain).
- Expected systemic vaccine side effects in previous COVID-19 vaccines (fever, chills, fatigue, headache, lymphedema, diarrhea, myalgia, arthralgia).
- Previous COVID-19 infection.
- Vasovagal reaction after receiving a dose of any vaccination.

- Being an immunocompromised individual or receiving immunosuppressive medications.
- Autoimmune conditions, including Guillain-Barre Syndrome.
- Allergic reactions to anything not contained in the COVID-19 vaccine, including injectable therapies, food, pets, oral medications, latex etc. (Please note the COVID vaccine does not contain egg or gelatin).
- Alpha-gal Syndrome.
- Pregnancy, undergoing fertility treatment, intention to become pregnant or breast-feeding. (Please note the American College of Obstetricians and Gynecologists, the Society for Maternal-Fetal Medicine and the Society for Reproductive Medicine all strongly recommend COVID-19 vaccination during pregnancy).
- The medical condition of a family member or other residing in the same household as the employee.

Clinician Certification: **By completing this form, you certify that different methods of vaccinating against COVID-19 have been fully considered and that the patient has the contraindication indicated above that precludes any/all available vaccinations for COVID-19.** Information about approved medical exemptions for COVID-19 vaccination can be reviewed at <https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html>

## **Section B. Medical Provider Certification of Disability That Makes COVID-19 Vaccination Inadvisable**

*“Disability” is defined as any impairment resulting from anatomical, physiological, genetic, or neurological conditions which prevents the exercise of a normal bodily function or is demonstrable by medically accepted clinical or laboratory diagnostic techniques and any other condition recognized as a disability under applicable law.*

*“Disability” may include pregnancy, childbirth, or a related medical condition where reasonable accommodation is medically advisable.*

I certify that my patient (named above) has the following disability that makes COVID-19 Vaccination inadvisable: \_\_\_\_\_

Additional details on why the disability listed above makes COVID-19 Vaccination Inadvisable (to be completed by the medical provider):

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The patient’s disability is: ☐ Permanent  
☐ Temporary

If temporary, the expected end date is: \_\_\_\_\_

**Section C. Medical Provider Information**

Provider Name: \_\_\_\_\_

Provider National Provider Identifier (NPI): \_\_\_\_\_

Provider Specialty: \_\_\_\_\_

Provider Employer/Affiliation: \_\_\_\_\_

Provider Phone: \_\_\_\_\_

Provider Signature: \_\_\_\_\_ Date of signature: \_\_\_\_\_