Provider Justification for Exemption from COVID-19 Vaccination

Patient Information

Name:

Date:

College ID#:

CCC&TI Email:

Phone:

Provider: Please certify the medical reason that the patient should not be immunized for COVID-19 by completing this form and attaching available supporting documentation. Medical exemption requests require documentation from an appropriate health care provider who is authorized to diagnose the medical condition that necessitates the exemption. The information provided on this form will be reviewed by the college in consideration of the exemption request.

Option 1 – Allergy

◯ A documented history of a severe allergic reaction to any component of a COVID-19 vaccine or to a substance that is cross-reactive with a component. Please indicate in the explanation space below which vaccine(s) are contraindicated and name the components, by vaccine. (Note: since egg-free vaccine is available, history of egg allergy will not be accepted as a routine medical exemption).

◯ A documented history of a severe allergic reaction after a previous dose of the COVID-19 vaccine. Please indicate in the explanation space below to which vaccine the patient had a reaction and the date of the vaccine with type of reaction.

Option 2 – Physical Condition/Medical Circumstance

◯ The physical condition of the patient or medical circumstances relating to the individual are such that immunization is not considered safe. Please state in the explanation space below, with sufficient detail for independent review, the specific nature and probable duration of the medical condition or circumstances that contraindicate immunization with the COVID-19 vaccine.

Explanation (Additional documentation can be attached as needed)

Certification:

I certify that the information I have provided above is accurate to the best of my knowledge and that I support the request for a medical exemption from the COVID-19 vaccination requirement. Medical

exemption requests require documentation from an appropriate health care provider who is authorized to diagnose the medical condition that necessitates the exemption.

Provider Information

Medical Provider Name:

Medical Provider Specialty:

Provider's Practice:

Address:

Email:

Phone:

Signature: