

# SAMPLE VACCINE MEDICAL EXCEPTION FORM

**REQUEST FOR MEDICAL EXCEPTION FROM** **COVID-19 VACCINATION**

PLEASE PRINT THE FOLLOWING INFORMATION:

Name:

E-mail:

Department:

Physician Name:

Date of Birth:\_ \_/ \_/

Phone #: Supervisor/Manager Physician Phone No.:

Dear Physician:

FACILITY NAME requires COVID-19 vaccination similar to other required vaccinations such as MMR and varicella. COVID-19 vaccination has been mandated by NYS for all healthcare workers because it has been shown to be effective in reducing the incidence and severity of COVID-19 infection. If any licensed physician or certified nurse practitioner certifies that immunization with COVID-19 vaccine is detrimental to a staff member, based upon an allergy to components of the vaccine or a specific pre-existing health condition, the requirements of this section relating to COVID-19 immunization shall be subject to a reasonable accommodation of such health condition only until such immunization is found no longer to be detrimental to the health of such member. The nature and duration of the medical exemption must be stated in the personnel employment medical record and must be in accordance with generally accepted medical standards.

The above named person is requesting an exception from this vaccination requirement.

Please complete the form below. Should you have any questions, please contact FACILTIY NAME at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. Thank you.

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## The above person should not be immunized for COVID-19 for the following reasons (check all that applies):

# 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 which of the following vaccines 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.

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* + Moderna - List the component(s):
	+ Pfizer (Comirnaty) - List the component(s):
	+ Janssen/Johnson & Johnson - List the component(s)

 A documented history of a severe allergic reaction after a previous dose of the COVID-19 vaccine. Please indicate to which vaccine the patient had a reaction and the date of the vaccine & reaction

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* + Moderna - Date of Vaccine & Reaction: \_
	+ Pfizer - Date of Vaccine & Reaction:
	+ Janssen/Johnson & Johnson - Date of Vaccine & 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 the basis for why the medical condition or circumstances contraindicate immunization with the COVID-19 vaccine.

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Explanation:

# Option 3 – Other

 Other. Please provide this information in a separate narrative that describes why you opine that the patient should be exempt from vaccination, including reference to the medical condition or disability that forms the basis for your opinion.

Explanation:

# Certification

I certify that (patient name) has the above contraindication and support the request for a medical exemption from the COVID-19 vaccine requirement at .

# Provider Information

 Medical Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Provider License #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Medical Provider Specialty:

 Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (*Note: Signature Stamp Not Acceptable*)

 Name of Provider Company:

 Address:

 Email:

 Phone number:

I certify that has the above contraindication and request a medical exception from COVID-19 vaccination.

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## PLEASE FAX, E-MAIL OR MAIL THIS TO:

INSERT NAME, MAILING ADDRESS, FAX NUMBER & EMAIL ADDRESS

**DESIGNATED OFFICE USE ONLY:**

Medical Exception Approved on: / / Approving Staff Signature: