



Request for Medical Exemption from COVID-19 Vaccination Form

Name: _____

COA Email: _____ Phone: _____

College of the Atlantic (COA) requires all students, staff, and faculty receive a COVID-19 vaccination. **A medical exemption may be granted upon receipt of a completed form (below) not more than six months old, signed and certified by a licensed healthcare provider, not related to the submitter, and whose specialty is appropriate to the associated condition that includes the following:**

Medical exemptions expire when the medical condition(s) contraindicating COVID-19 vaccination changes in a manner which permits vaccination or upon graduation. The assigned expiration is at the sole determination of COA.

Individuals with an approved exemption will be required to comply with additional testing and other preventive protocols as specified in the exemption approval and may be updated by later notification and/or posting of requirements on the COA website. In the event of an outbreak on or near campus, individuals holding exemptions may be excluded from all campus facilities and activities, for their protection, until the outbreak is declared to be over.

The COA COVID-19 Response Team, or a subset thereof, will review all requests, though approval is not guaranteed. After your request has been reviewed and processed, you will be notified, in writing, if an exemption has been granted. If the approved exemption contains an expiration, you will be expected to complete the requirement at that time. Should the condition continue, or a new vaccination contraindication occurs, or the current exemption expires, a new request with updated documentation is required. Decisions are final and not subject to appeal. Individuals are permitted to reapply if new documentation and information should become available.

In order to submit a request, please:

- Read the [CDC COVID-19 Vaccine Information](#);
- Complete the following page of this form;
- Have your Licensed Health Care Provider complete the provider section of this form;
- Submit the completed documents

Note: Incomplete submissions will not be reviewed. Be sure all forms and documentation are submitted at one time.

Initial next to each of the statements below:

	I request exemption from the COVID-19 vaccination requirements due to my current medical condition . I understand and assume the risks of non-vaccination. I accept full responsibility for my health, thus removing liability from COA to the required vaccination.
	I understand that as I am not vaccinated, in order to protect my own health and the health of the community, I will comply with all COVID-19 testing protocols.
	I understand that in the event of an outbreak or threatened outbreak, I may be temporarily excluded from COA facilities and approved activities. I agree to comply with these restrictions and accept responsibility for communicating with staff, faculty, and advisors as appropriate to allow compliance with health and safety protocols for unvaccinated individuals.
	Should I contract COVID-19, I will <u>immediately</u> report it to the COVID-19 Coordinator and comply with all isolation and quarantine protocols.
	I acknowledge that I have read the CDC COVID-19 Vaccine Information .
	I understand that this exemption will expire when the medical condition(s) contraindicating vaccination changes in a manner which permits vaccination.
	I understand and agree to comply with and abide by all COA COVID-19 policies and protocols.
	I understand that this exemption is only valid for the approved period and I may need to submit a new request for any subsequent changes, new medical contraindications, or on expiration of an approved exemption.
	I authorize my licensed health care provider to provide COA with medical information about my <u>medical exemption for the COVID-19 vaccination</u> .
	I certify that the information I have provided on and in connection with this request is accurate and complete as of the date of this submission. I understand this exemption may be revoked and I may be subject to COA disciplinary action if any false information has been used to request an exemption.

Printed Name: _____

Signature: _____

Date: _____

COA Email: _____

Phone Number: _____

By checking this box and typing my name above, I understand and agree that I am submitting this document electronically and that it is the legal equivalent of having placed my handwritten signature on the submitted document. Date: _____

Attention Health Care Provider:

College of the Atlantic policy requires that all students receive a COVID-19 vaccination.
_____ (insert patient's name) is requesting a medical exemption from this vaccination requirement. A medical exemption may be allowed for certain recognized contraindications.

Please certify below the medical reason that your patient should not be immunized for COVID-19 by completing this form and attaching available supporting documentation. Information provided on this form will be reviewed by a confidential committee 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 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.

- Moderna - List the component(s): _____
- Pfizer - 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.

- 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, with sufficient detail for independent medical review, the specific nature and probable duration of the medical condition or circumstances that contraindicate immunization with the COVID-19 vaccine.

Explanation:

Option 3 – Other

Please provide this information in a separate narrative that describes, in detail, the medical condition or disability in detail that you opine would exempt this individual from vaccination:

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 College of the Atlantic.

Provider Information

Medical Provider Name: _____

Medical Provider Specialty: _____

Signature: _____

Provider License Number: _____

Date: _____

Name of Provider Company: _____

Address: _____

Email: _____

Phone Number: _____

Patient Information

Patient Name: _____

Date: _____

COA Email: _____

Phone Number: _____

Once you have completed this document:

Staff/Faculty: Email to covid19coordinator@coa.edu.