COVID-19 Vaccination Medical Exemption Request

Name: ______________________________________ Date of Birth: _______/________/____________
Email Address: ________________________________ Phone Number: _________________________
Department/School: _____________________________ Student ID: _____________

Physician Attestation

By completing this form, you certify that different methods of vaccinating against COVID-19 have been considered, and that the following medical contraindication precludes all vaccinations for COVID-19. Guidance for medical exemptions for COVID-19 vaccination can be obtained from the Advisory Committee on Immunization Practices (ACIP) available at https://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html.

Please select contraindication below (attach supporting documentation or medical records):

____Severe allergic reaction (anaphylaxis) after a previous dose of or to a component of the COVID-19 vaccine, including polyethylene glycol (PEG). *Please describe response in detail below and contraindication to alternatives, such as the Johnson & Johnson vaccine, which does not contain PEG.*

____Immediate allergic reaction to a previous dose or known (diagnosed) allergy to a component of the vaccine. *Please describe response in detail below and contraindication to alternative vaccines.*

____Other medical circumstance preventing vaccination with any available COVID-19 vaccine *(describe specifically below or in a separate narrative).*

Physician printed name: ____
Physician signature: ____
(Note: Signature stamp not acceptable)
Date: ______/______/______ Medical License No.: ______________________
Physician phone number: ____

<u>Please fax or mail this form to</u>: Washington State Community College ATTN: Director of Nursing, 710 Colegate Drive, Marietta, Ohio 45750. Office: 740.374.8716 or Fax: 740.568.1983

COVID-19 Vaccination Religious Exemption Request

Name: ______________________________________ Date of Birth: _______/________/____________
Email Address: ________________________________ Phone Number: _________________________
Department/School: _____________________________ Student ID: _____________

Religious Leader Attestation

Students whose religious beliefs prevent them from obtaining the COVID-19 vaccination must submit the Religious Exemption Request Form. If your religious beliefs or practices conflict with COVID-19 vaccination requirement, please provide the following information.

Please explain why you are seeking an exemption?

____
____
____
____

Religious Leader/Clergy: ________________________________

Address: _______________________________ Contact number: ___________________

In some cases, additional information and/or documentation about your religious practice(s) or belief(s) may need to be obtained. If requested, can you provide documentation to support your belief(s) and need for an accommodation? YES ☐ NO ☐

If no, please explain why:

____
____
____

Are you attaching any supporting documentation to this request? YES ☐ NO ☐

Verification and Accuracy

I verify that the above information is complete and accurate to the best of my knowledge, and I understand that any intentional misrepresentation contained in this request may result in disciplinary action, including dismissal from the program.

Signature: ______________________________ Date: _____________

Print Name: ____________________________

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