Request for Medical Immunization Exemption Form - Provider

Name of Student (Please Print): ________________________________________________________________

COVID-19 vaccination is required for all St. John’s University students returning to campus for the Fall 2021 semester. A student may be exempt from COVID-19 vaccination for medical reasons. Please review the CDC guidance regarding contraindications for COVID-19 vaccines to assist in determining the medical justification for a medical exemption.

Please describe how the COVID-19 vaccine (Pfizer-BioNTech/Moderna/Johnson & Johnson) is medically contraindicated. This statement must specify the length of time the immunization may be medically contraindicated and specify the date the student is permitted to be vaccinated.

**Medical Provider Certification of Contraindication**: I certify that my patient (named above) should not be vaccinated against COVID-19 because they have one of the following contraindications:

- □ Documented anaphylactic allergic reaction or other severe adverse reaction to any COVID-19 vaccine – e.g., cardiovascular changes, respiratory distress, or history of treatment with epinephrine or other emergency medical attention to control symptoms. Generally, does not include gastro-intestinal symptoms as the sole presentation of allergy. **Describe the specific reaction:** _____________________________________________________________
  ____________________________________________________________________________________
  ____________________________________________________________________________________

- □ Documented allergy to a component of the vaccine – does not include sore arm, local reaction, or subsequent respiratory tract infection. **Describe the specific reaction:** _____________________________________________________________
  ____________________________________________________________________________________
  ____________________________________________________________________________________

- □ Other documented contraindication. **Describe the specific reaction:** ____________________________
  ____________________________________________________________________________________
  ____________________________________________________________________________________

Date:
Signature of Health Care Provider:

______________________________

Name: (print):

______________________________

Profession: □ MD □ DO □ NP □ Midwife License Number/State: _________________ /

Address/Phone or Clinic Stamp: