ST. JOHN'S UNIVERSITY

Request for Medical Immunization Exemption Form - Health Provider

Name of Student (Please Print): _____

COVID-19 vaccination is required for all St. John's University students entering campus during the **Spring 2023** semester. A student may be exempt from COVID-19 vaccination for medical reasons.

1) Please review the CDC guidance (https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html#Contraindications) regarding contraindications for COVID-19 vaccines to assist in determining the medical justification for a medical exemption.
2) Only those individuals meeting criteria for contraindications and precautions to COVID-19 vaccines as articulated by the CDC will be considered for medical exemption.
3) Please specify the length of time the immunization may be medically contraindicated and specify the date the student is permitted to be vaccinated

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. **Documentation must outline the specific contraindication. Nondescript notes are not sufficient.**

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 the date the student is permitted to be vaccinated:**

_____

_____

_____

☐ Documented allergy to a component of the vaccine – does not include sore arm, local reaction, or subsequent respiratory tract infection. **Describe the specific reaction the date the student is permitted to be vaccinated:**

_____

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_____

☐ Other documented contraindication. **Describe the specific reaction the date the student is permitted to be vaccinated:**_____

_____

_____

Date:

Signature of Health Care Provider: _____ Name: (print): _____

Profession: ☐ MD ☐ DO ☐ NP ☐ Midwife License Number/State: _____ / _____

Address/Phone or Clinic Stamp: