REQUEST FOR MEDICAL COVID-19 VACCINE EXEMPTION

Please upload Completed Form to CastleBranch (or Typhon, for DNP students).

STUDENT COMPLETE:

Name:_____ Student ID Number: _____

Academic Program: _____ Phone Number: _____

ACKNOWLEDGEMENT

You do have a choice to not be vaccinated. Unfortunately, clinical sites do not have to accept students who are not vaccinated even with exemptions. I understand that if I am not vaccinated, I will be required to wear a mask or use other protective devices while on campus, in patient care areas, or healthcare facilities. I may be required to pay for these protective devices. I understand that I am required to remove myself from classrooms and clinical rotations at the first sign of infection/ disease. I understand that I may not return until cleared by Campus Health. I understand that in case of a communicable disease breakout, I may be temporarily excluded from classes, clinical rotation, student housing, and campus at the discretion of Campus Health.

I understand that I may be excluded from participation in clinical activities based on my vaccination status, and thus unable to progress in my program, due to clinical site-specific vaccination policies. NMC is required to follow those policies and cannot prepare simultaneous or virtual alternate clinical plans for students that are unable to attend clinical/fieldwork due to vaccination status. I understand that I am responsible for informing my clinical instructors of my vaccination status so that they may assist me in determining agency requirements and patient assignments. I understand that failure to comply with these requirements may result in disciplinary action up to and including dismissal from the program. I understand that I may change my mind at any time and accept the COVID-19 vaccination, if the vaccine is still available. I understand that I may be putting not only myself, but also my patients for whom I care, at risk.

If I am granted an exemption, I certify the above information to be true and accurate. I understand and agree to the above Acknowledgement, and agree to abide by all NMC protocol for unvaccinated students.

Student Signature: _____

PROVIDER COMPLETE:

CMS regulations require COVID-19 vaccination for all staff without sincerely held religious objections or medical contraindications. Your patient (listed above) is requesting a medical exemption from receiving the COVID-19 vaccine based on a recognized medical condition for which vaccines are contraindicated, as a reasonable accommodation under the Americans with Disabilities Act (ADA). Guidance for medical contraindications for COVID-19 vaccination can be obtained from the Advisory Committee on Immunization Practices (ACIP) available at: https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html.

Please note, the following are not considered contraindications to COVID-19 vaccination:

- Local injection site reactions after (days to weeks) previous COVID-19 vaccines
- Expected systemic vaccine side effects in previous COVID-19 vaccines
- Previous COVID-19 infection
- Vasovagal reaction after receiving a dose of any vaccination
- Being an immunocompromised individual or receiving immunosuppressive medications
- Autoimmune conditions, including Guillain-Barre Syndrome
- Allergic reactions to anything not contained in the COVID-19 vaccines, including injectable therapies, food, pets, venom, environmental allergens, oral medication, latex, etc. Please note that the COVID-19 vaccines do not contain eggs or gelatin.
- Immunosuppressed person in the healthcare worker's household
- Alpha-gal Syndrome
- Family member or household member who falls into a medically exempt category

(continued on next page)

(REQUIRED – Please include as much detail as possible)

It is my opinion that my patient referenced above has the following contraindication to COVID-19 vaccination:

_____

_____

_____

_____

_____

☐ Temporary deferral from COVID-19 vaccination due to recent receipt of COVID-19 monoclonal antibodies or convalescent plasma, a recent COVID-19 diagnosis or recent multisystem inflammatory syndrome in adults (MISA).

Date eligible to receive COVID-19 vaccination: _____

I certify the above information to be true and accurate, and request exemption from the COVID-19 vaccination for the individual named above.

_____

Printed Physician Name and Address

_____

Physician Signature Date

MEDICAL EXEMPTION PANEL COMPLETE:

☐ Accepted Medical Exemption

☐ Denied Medical Exemption

If the request was rejected, please indicate why below:

_____

_____

_____

_____

_____

Printed Reviewer Name _____

Reviewer Signature_____ Date _____