

**REQUEST FOR MEDICAL EXEMPTION FROM COVID-19 VACCINATION**

Daemen College is committed to building an inclusive and welcoming campus environment.

If you have an allergy to the COVID-19 vaccine or a specific medical condition that precludes the COVID-19 vaccination requirement and you seek a medical exemption from receiving the COVID-19 vaccination, please consult with your physician and provide the following information on this form and provide a copy of your vaccination records.

**Please print the following information:**

**Name:** \_\_\_\_\_ **Job Title:** \_\_\_\_\_

**Supervisor:** \_\_\_\_\_ **Department:** \_\_\_\_\_

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**Physician Name:** \_\_\_\_\_ **Physician Phone No.:** \_\_\_\_\_

**Physician Address:** \_\_\_\_\_

Dear Physician:

Per Federal guidance, Daemen College is encouraging all faculty and staff to get their COVID-19 vaccinations. However, we recognize there are certain medical exemptions from the COVID-19 vaccination as recognized contraindications (<https://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html>).

Please complete the form below. Thank you.

The above person should not be immunized for COVID-19 for the following reasons (Please check all that apply):

Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a component of the COVID-19 vaccine

\_\_\_\_\_  
\_\_\_\_\_

Immediate allergic reaction of any severity to a previous dose or known (diagnosed) allergy to a component of the vaccine (Vaccine Ingredients) <https://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html#Appendix-C>

\_\_\_\_\_  
\_\_\_\_\_

Other Medical Reason – Please provide this information in a separate narrative that describes the other medical reason justifying an exemption in detail.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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How long have you been treating this individual for any of the above mentioned medical conditions?

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**PHYSICIAN CERTIFICATION**

I certify that \_\_\_\_\_ has the above contraindication or specific medical condition and request a medical exemption from COVID-19 vaccination.

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Medical License No.: \_\_\_\_\_ NPI No.: \_\_\_\_\_

**EMPLOYEE ACKNOWLEDGEMENT**

I verify that the above information I have provided is complete and accurate to the best of my knowledge, and I understand that any intentional

