

Request for Medical Exemption from COVID-19 Vaccine Requirement

Team Member: Complete the following information

Name (last, first, MI): _____ Team Member ID Number: _____

Email Address: _____ Best Phone Number: _____

After you and your provider complete this form, submit it to the SRH Employee Health Dept. Information will be kept only in your confidential SRH Employee Health record. After review and approval of this request, compliance records will be updated within one week.

Provider Section: A licensed Physician, Physician's Assistant, or Nurse Practitioner must complete and sign this section. Forms completed by the requesting individual will **NOT** be accepted.

Physician/Provider Instructions: By completing this form, you certify that different methods of vaccinating against COVID-19 have been considered, and that the following medical contraindication(s) precludes any/all vaccinations for COVID-19.

Guidance for current 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>.

The following are **NOT** considered contraindications to COVID-19 vaccination:

- Local injection site reactions after (days to weeks) previous COVID-19 vaccines (erythema, induration, pruritus, pain, etc.)
- Expected systemic vaccine side effects in previous COVID-19 vaccines (fever, chills, fatigue, headache, lymphadenopathy, vomiting, diarrhea, myalgia, arthralgia)
- 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.
- Breastfeeding
- Immunosuppressed person in the employee's household
- Alpha-gal Syndrome
- **The COVID vaccines do not contain egg or gelatin, allergies to these substances are not a contraindication**

Please select medically indicated contraindication and explain below: (additional documentation may be attached)

- ☐ 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 available COVID-19 vaccines (Be specific & describe in detail below)

Signature of Healthcare Provider: _____ Date: _____

Printed Provider Name: _____ Practice Telephone #: _____

FOR OFFICE USE ONLY:

Date Request Received: _____

Request Received By: _____