+rmc
Regional Medical Center

REQUEST FOR MEDICAL EXEMPTION TO THE COVID-19 VACCINE

Name: _____

ID#: _____

I am claiming a medical exemption from vaccination against COVID-19. The information provided on this form in complete and accurate.

Employee Signature:_____
Printed Name: _____
Date:_____

Below portion to be completed by the employee's health care provider (MD, DO, NP, or PA only):

Provider Review:

Vaccinations may not be appropriate for a small number of individuals (e.g., individuals with a history of severe reactions to a previous vaccine component). Guidance for medical exemptions for COVID-19 vaccination can be viewed at https://www.cdc.gov/vaccines/covid-19/clinical-considerations/index.html.

Please note that the following are **NOT** considered contraindications to COVID-19 vaccination:

1. Local injection site reactions after previous COVID-19 vaccines (erythema, induration, pruritus, pain)
2. Expected systemic vaccine side effects (e.g. fever, chills, fatigue, headache, lymphadenopathy, vomiting, diarrhea, myalgia, arthralgia)
3. Vasovagal reactions after receiving a dose of any vaccination
4. Being an immunocompromised individual or receiving immunosuppressive medications
5. Certain autoimmune conditions
6. Allergic reactions to items not contained in the COVID-19 vaccines, including injectable therapies, food, pets, venom, environmental allergens, oral medications, latex, etc.
7. Immunosuppressed person in the employee's household
8. Alpha-gal Syndrome
9. Allergy to egg or gelatin
10. Having a positive antibody titer

Pregnancy may or may not be a temporary exemption ground (see below). Lactation alone is not a category for exemption

Medical reasons for requested exemption (check all that apply):

Pfizer/Moderna vaccine series:

☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to vaccine components
☐ Allergy to specific component of the vaccine (please specify: _____)
☐ Other (please specify: _____)

Astra Zeneca/Janssen (Johnson & Johnson) vaccine series:

☐ Personal history of Guillain-Barre Syndrome within 6 weeks of receiving any vaccine.
☐ Severe allergic reaction (e.g. anaphylaxis after a previous dose or to vaccine components
☐ Allergy to specific component of the vaccine (please specify: _____)
☐ Other (please specify: _____)

For any COVID-19 vaccination series, **we will accept pregnancy as a temporary exemption if the vaccine is under emergency use authorization (i.e. not applicable to Pfizer series).** Please indicate estimated date of conception (EDC) below and document verified pregnancy.

☐ Documented Pregnancy (please indicate EDC: _____)

Other condition

☐ Specify _____
_____
_____
_____
_____

Please provide documentation and indicate whether this medical contraindication is permanent or temporary and timeframe for re-evaluation if less than 1 year. Please attach documentation to support the diagnosis and assessment.

Provider Statement of Exemption

The physical condition of the above-named employee is such that vaccination would endanger their life or health or is medically contraindicated due to other medical conditions as specified above.

Provider Name:_____
Provider Signature: _____
Provider License Number:_____
Date: _____