



Request for Medical Exemption from COVID-19 Vaccine

Name: _____ ID# (If applicable): _____

Date of Birth: _____ Phone Number: _____

Dominican University email: _____

Dominican University recommends that all students and employees receive a COVID-19 vaccination.

A medical exemption may be granted upon receipt of a completed form (below) not more than 1 month old, signed and certified by a licensed physician, not related to the submitter, and whose specialty is appropriate to the associated condition.

Medical exemptions expire when the medical condition(s) contraindicating COVID-19 vaccination changes in a manner which permits vaccination or upon the conclusion of the academic semester. The assigned expiration is at the sole determination of Dominican University.

Individuals with an approved exemption will be required to comply with additional testing and other preventive requirements as specified in the exemption approval and as may be updated by later notification. In the event of an outbreak on or near campus, individuals holding exemptions may be excluded from all campus facilities and activities, for their protection, and the protection of the University community, until the outbreak is declared to be over. The Exemption Committee will review all requests, though approval is not guaranteed.

After your request has been reviewed and processed, you will be notified, in writing, if an exemption has been granted. If the approved exemption contains an expiration, you will be expected to complete the requirement at that time. Should the condition continue, or a new vaccination contraindication occurs, or the current exemption expires, a new request with updated documentation is required. Decisions are final and not subject to appeal. Individuals are permitted to reapply if new documentation and information should become available.



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Initial Below	Carefully Review Statements
	I request exemption from the Covid-19 vaccination requirements due to my current medical condition. I understand and assume the risks of non-vaccination. I accept full responsibility for my health, thus removing liability from Dominican University regarding my non-vaccination.
	I understand that as I am not vaccinated, in order to protect my own health and the health of the community, I will comply with additional Covid-19 testing requirements and other preventative guidance.
	I understand that in the event of an outbreak or threatened outbreak, I may be temporarily excluded from Dominican University facilities and approved activities (including but not limited to housing, if applicable). I agree to comply with these restrictions and accept responsibility for communicating with the Health Center as appropriate to allow compliance with health and safety requirements for unvaccinated individuals. I further understand that restrictions from Dominican University facilities, including but not limited to classes and living and work spaces, does not entitle me to any reduction in tuition, housing charges, or other University fees or any other fees.
	Should I contract Covid-19, I will immediately contact the Health Center and comply with all isolation and quarantine protocols specified by Dominican University, regardless of any symptoms. I will remove myself from the Dominican University campus and/or find temporary accommodations at my own expense if so advised, if applicable.
	I understand that this exemption will expire when the medical condition(s) contraindicating vaccination changes in a manner which permits vaccination or at the conclusion of the academic semester, whichever is first.
	I understand and agree to comply with and abide by all Dominican University COVID-19 policies and procedures.
	I understand that this exemption is only valid for one academic semester. I am aware that I am required to submit a new request for any subsequent changes, new medical contraindications, or on the expiration of an approved exemption.
	I authorize my licensed health care provider to provide Dominican University with medical information regarding my medical exemption for the COVID-19 vaccination.
	I understand that vaccine exemption by the University does not imply exemption for off-campus obligations such as clinical hours, field experience, student teaching, or other programming affiliated with our partner sites.
	I certify that the information I have provided on and in connection with this request is accurate and complete as of the date of this submission. I understand this exemption may be revoked and I may be subject to Dominican University disciplinary action if any false information has been used to request an exemption.

Name: _____ ID# (If applicable): _____

Signature: _____ Date: _____

Phone Number: _____ DUNY Email: _____



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Option 1 - Allergy

A documented history of a severe allergic reaction to any component of a COVID-19 vaccine or to a substance that is cross-reactive with a component. Please indicate which of the following vaccines are contraindicated and name the components, by vaccine. NOTE: Since egg free vaccine is available, history of egg allergy will not be accepted as a routing medical exemption.

- Moderna – List the component(s): _____
- Pfizer – List the component(s): _____
- Janssen/Johnson & Johnson – List the component(s): _____
- Other – List the components(s): _____

A documented history of a severe allergic reaction after a previous dose of the COVID-19 vaccine.

Please indicate to which vaccine the patient had a reaction and the date of the vaccine & reaction:

- Moderna – Date & reaction: _____
- Pfizer - Date & reaction: _____
- Jansen/Johnson & Johnson – Date & reaction: _____
- Other – _____ Date & reaction: _____

Option 2 – Physical Condition/Medical Circumstance

The physical condition of the patient or medical circumstances relating to the individual are such that immunization is not considered safe. Please state, with sufficient detail for independent medical review, the specific nature and probable duration of the medical condition or circumstances that contraindicate immunization with the Covid-19 vaccine.

Explanation:



Option 3 – Other

Please provide this information in a separate narrative that describes, in detail, the medical condition or disability in detail that you opine would exempt this individual from vaccination:

Certification

I certify that (patient name)_____has the above contraindication and support the request for a medical exemption from the COVID-19 vaccine requirement at Dominican University.

Provider Information

Provider Name: _____

Medical Provider Name/Company: _____

Medical Provider Specialty: _____

Medical Provider Signature: _____ Date: _____

Medical Provider License Number: _____

Address: _____

Phone Number: _____

Email: _____

Patient Information:

Patient Name _____ Date _____

Phone Number: _____ DUNY email: _____

Completed document must be sent to Covid-19.Exemption@duny.edu
