Request for Medical Exemption from COVID-19 Vaccine

Name: _____ ID# (If applicable): _____

Date of Birth: _____ Phone Number: _____

Dominican College email: _____

Dominican College 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 College.

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 College 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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	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 College 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 College 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 College 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 college 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 College, regardless of any symptoms. I will remove myself from the Dominican College 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 College 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 College with medical Information regarding my medical exemption for the COVID-19 vaccination.
	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 College disciplinary action if any false information has been used to request an exemption.

Name: _____ ID# (If applicable): _____

Signature: _____ Date: _____

Phone Number: _____ Dominican College 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 & Johnston – List the component(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 of Vaccine & reaction: _____
- Pfizer - Date of Vaccine & Reaction: _____
- Jansen/Johnson & Johnson – Date of Vaccine & 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 College.

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 _____

Dominican College email: _____ Phone Number: _____

Once you have completed this document, it must be sent to Covid-19.Exemption@dc.edu.