SUNY Niagara County Community College

COVID-19 Vaccination Requirement Medical Exemption Request Form

To request a medical exemption from the SUNY COVID-19 Vaccination requirement, please complete this form and submit it to the Wellnesss Center, C-122. A written decision regarding your request will be released through the mail. You will be contacted prior so you are aware of the decision.

Part I. Student Information and Certification:
Student Name:
Student ID Number: _@
Student Date of Birth:
Student Street Address:
Student City/State/Zip:
Student Phone:
Student Email Address:
Please check each box to acknowledge:
☐ While my request is pending, I understand that I must comply with the campus' COVID-19 related health and safety protocols (e.g., masks/face coverings, social distancing, regular surveillance testing) applicable to unvaccinated or partially vaccinated individuals as a condition of my physical presence in a SUNY Facility.
$\ \square$ I certify that I have confirmed with my academic program that not receiving the COVID-19 Vaccination will not prevent the completion of my programmatic or curricular requirements.
☐ If my request is granted, I understand that I will be required to comply with the campus' COVID-19 related health and safety protocols (e.g., mask/face coverings, social distancing, regular surveillance testing) if accessing a SUNY Facility as a condition of my on-going physical presence. I am aware that should a COVID-19 outbreak occur at the campus that I may be excluded from all in-person classes and activities and that if I am enrolled in courses that require a physical presence on campus that I may not be able to complete my academic coursework

remotely. I acknowledge that any refund I might be entitled to in the case of a COVID-19 outbreak would be

subject to all existing SUNY policies.

\Box I certify that my statements above, and all supporting documentation, are true and accurate, and that the receipt of the COVID-19 vaccination may be detrimental to my health.			
Please sign in the space provided below and have the document notarized by a notary public where indicated			
Signature of Student	Date		
*Parent/Guardian Cosign For Minor Students:			
Signature of Parent/Guardian	Date		
Subscribed and sworn to before me this			
day of, 20			
Notary Public			

Please note that the campus reserves the right to request additional documentation to support a request for a medical exemption.

Part II. Medical Exemption Request (to be completed by medical provider)

A licensed medical provider (Physician, Physician's Assistant, or Nurse Practitioner) and student should review the CDC guidance regarding contraindications for COVID-19 vaccines. The provider must complete Section(s) A and/or B and provide their provider information in Section C.

<u>Section A. Medical Provider Certification of Contraindication</u>: I certify that my patient (named above) cannot be vaccinated against COVID-19 because of the following contraindication:

Ple	se select which of the medically indicated COVID-19 vaccine contraindications defined by the CDC apply:		
	Severe allergic reaction (anaphylaxis) after a previous dose or to a component of the COVID-19 Vaccine, including Polyethylene Glycol (PEG). (<i>Describe reaction/response below and contraindication to alternative vaccines</i> .)		
	Immediate allergic reaction to previous dose or known (diagnosed) allergy to a component of the vaccine (<i>Describe reaction/response below and contraindication to alternative vaccines</i>).		
Add	itional details on the selected option(s) above (to be completed by the medical provider):		

Please note that **NONE of the following are considered contraindications** to the COVID-19 vaccine.

- Local injection site reactions to previous COVID-19 vaccines (erythema, induration, pruritus, pain).
- Expected systemic vaccine side effects in previous COVID-19 vaccines (fever, chills, fatigue, headache, lymphedema, diarrhea, myalgia, arthralgia.
- Previous COVID-19 infection.
- 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 vaccine, including injectable therapies, food, pets, oral medications, latex etc. (Please note the COVID vaccine does not contain egg or gelatin).
- Alpha-gal Syndrome.
- Pregnancy, undergoing fertility treatment, intention to become pregnant or breast-feeding. (Please note the American College of Obstetricians and Gynecologists, the Society for Maternal-Fetal Medicine and the Society for Reproductive Medicine all strongly recommend COVID-19 vaccination during pregnancy).
- The medical condition of a family member or other residing in the same household as the student.

Clinician Certification: By completing this form, you certify that different methods of vaccinating against COVID-19 have been fully considered and that the patient has the contraindication indicated above that precludes any/all available vaccinations for COVID-19. Information about approved medical exemptions for COVID-19 vaccination can be reviewed at https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html

Section B. Medical Provider Certification of Disability That Makes COVID-19 Vaccination Inadvisable

"Disability" is defined as any impairment resulting from anatomical, physiological, genetic, or neurological conditions which prevents the exercise of a normal bodily function or is demonstrable by medically accepted clinical or laboratory diagnostic techniques and any other condition recognized as a disability under applicable law.

"Disability" may include programmy childhirth, or a related medical condition where regrangles.

"Disability" may include pregnancy, childbirth, or a related medical condition where reasonable accommodation is medically advisable. I certify that my patient (named above) has the following disability that makes COVID-19 Vaccination inadvisable: Additional details on why the disability listed above makes COVID-19 Vaccination Inadvisable (to be completed by the medical provider): The patient's disability is: ☐ Permanent ☐ Temporary If temporary, the expected end date is: **Section C. Medical Provider Information** Provider Name: ______ Provider National Provider Identifier (NPI): Provider Specialty: ______ Provider Employer/Affiliation: ______ Provider Phone: ______ Provider Signature: Date of signature: