COVID 19 VACCINE MEDICAL EXEMPTION FORM

Name of Student: ID#			Date of Birth:			
Name of Parent/Guardian (if under 18): first/middle/last			Primary Phone:			
Patient/Parent Home Address 1	ess: address 2		city state zip			
Patient/Parent Email Address:						
Medical contraindications and precautions for immunizations are based on the most recent General Recommendations of the Advisory Committee on Immunization Practices (ACIP)/CDC, available at https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html or https://www.cdc.gov/vaccines/covid-19/index.html or https://redbook.aspx Please check the website to ensure that you are reviewing the most recent CDC/ACIP information. Please note that the presence of a moderate to severe acute illness with or without fever is a precaution to administration of all vaccines However, as acute illnesses are short-lived, medical exemptions should not be submitted for this indication.						
Table 1.	ACIP Contraindicati	ons and Precautions to Vac	cination for Mandatory Vaccines			
Vaccine	Exemption Length	ACIP Contraindications	•			
COVID19 Vaccine	Temporary through: Permanent	Contraindications Severe allergic reaction a vaccine component Other (explain below)	(e.g., anaphylaxis) after a previous dose or to			
Vaccine	Exemption Length	CDC/ACIP Contraindica	tions and Precautions			
Other. Please e.	xplain fully and attach	additional sheets as necessar	y.			
		Attestation				
I am a physician (M.D. or D.O) licensed to practice medicine in a jurisdiction of the United States or an advanced practice nurse licensed in a jurisdiction of the United States. By signing below, I affirm that I have reviewed the current CDC/ACIP Contraindications and Precautions and affirm that the stated contraindication(s)/precaution(s) is enumerated by the CDC/ACIP and consistent with established national standards for vaccination practices. I understand that I might be required to submit supporting medical documentation Healthcare Provider Name (please print):						
NPI Number:License Number:						
			State of Electionic.			
	Address: City: State: Zip: Signature: Date:					

COVID 19 VACCINE RELIGIOUS EXEMPTION FORM

ID#		Date of Birth.		
Name of Parent/Guardian (if under 18): first / midd	lle / last	Primary Phone:		
Patient/Parent Home Address: address 1	address 2	city	state	zip
Patient/Parent Email Address:				
Religious Exemption				
Explain how the COVID 19 (Attach document)	vaccination interferes with your fre	e exercise of your religious righ	ts.	
NAME				
SIGNATURE		DATE		