Tompkins Cortland Community College
COVID-19 Vaccination Requirement
Medical Exemption Request

To request a medical exemption from the SUNY COVID-19 Vaccination requirement, please complete this form and email it to TC3 Health Center (Rm. 118A) at healthcenter@tompkinscortland.edu.

Part I. Student Information and Certification:

LAST NAME	FIRST NAME	STUDENT EMAIL ADDRESS	DATE OF BIRTH	STUDENT ID #

Please check both boxes to acknowledge:

☐ 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.

☐ I certify that my health-related statements, and all supporting documentation, are true and accurate.

Signature*: ____ Date: ____________

*Student, but Parent or Legal Guardian must sign if the student is under 18 years old as of first day of classes.

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.

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

Please 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). (***Describe reaction/response below and contraindication to alternative vaccines***.)

☐ Immediate allergic reaction to previous dose or known (diagnosed) allergy to a component of the vaccine. (***Describe reaction/response below and contraindication to alternative vaccines***).

Additional 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 employee.

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 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: __________________