



Medical/Disability Exception Request

Accommodation to SARS-CoV-2 (COVID-19) Vaccination Requirement
v. 3/17/2022

PARTICIPANT INFORMATION	
Full Name	Birthdate MM / DD / YY
Parent/Guardian Full Name (if participant is under 18 years old)	

If the participant is under 18 years old, this form should be filled out by a parent/guardian.

<input type="checkbox"/> REQUEST FOR MEDICAL EXEMPTION	
Initials	The above named participant has a medical condition that contraindicates their vaccination with ALL of the currently available COVID-19 (SARS-CoV-2) vaccines.
Description of the contraindication and/or precaution	
This contraindication and/or precaution is... <input type="checkbox"/> PERMANENT <input type="checkbox"/> TEMPORARY	If temporary, the expected end date is...

<input type="checkbox"/> REQUEST FOR DISABILITY EXEMPTION	
“Disability” is defined as a physical or mental disorder or condition that limits a major life activity and any other condition recognized as a disability under applicable law. Providers are asked to carefully consider risk of severe COVID-19 disease.	
Initials	The above named participant has a disability as defined above that makes COVID-19 vaccination inadvisable.
This disability is... <input type="checkbox"/> PERMANENT <input type="checkbox"/> TEMPORARY	If temporary, the expected end date is...

ADDITIONAL INFORMATION (if applicable)
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MEDICAL PROVIDER CERTIFICATION		
By signing below, I verify that I am a licensed MD, DO, PA, or NP and I have read and certify the above.		
Full Name	Signature	Date/Time
License Number	License State & Country	License Type (MD, DO, PA, or NP)

By signing below, I verify the truth and accuracy of the statements in this request form.

Full Name of Parent/Guardian or Participant	Signature	Date/Time
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