Nassau Community College

COVID-19 Vaccination Requirement Medical Exemption Request Model Form

To request a medical exemption from the SUNY COVID-19 Vaccination requirement, please complete this form and submit it to the Student Health Office dropbox in the Student Services Center or email it to HealthOffice@ncc.edu. A decision regarding your request will be released through your NCC Student email. Please be sure to write your NCC Student email legibly below.

STUDENT EMAIL ADDRESS

DATE OF BIRTH

STUDENT ID#

Part I. Student Information and Certification:

FIRST NAME

LAST NAME

	Please ch	eck each box to acknowledge:		
protocols (e.g., masks	s/face coverings, socia	and that I must comply with the oral distancing, regular surveillance to physical presence in a SUNY Facil	esting) applicable to	
•	•	academic program that not receiving ricular requirements.	ng the COVID-19 Va	ccination will not pr
safety protocols (e.g. condition of my on-g be excluded from all on campus that I may	, mask/face coverings oing physical presenc in-person classes and not be able to comp	hat I will be required to comply wi s, social distancing, regular surveill e. I am aware that should a COVID I activities and that if I am enrolled lete my academic coursework rem atbreak would be subject to all exis	ance testing) if acce 0-19 outbreak occur d in courses that red notely. I acknowledg	essing a SUNY Facilit at the campus that quire a physical pre
☐ I certify that my st the COVID-19 vaccina		d all supporting documentation, anntal to my health.	re true and accurate	e, and that the rece
Signature*:		Date:		
*Student, but Parent	or Legal Guardian mu	ust sign if the student is under 18 y	rears old as of first o	day of classes.

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:

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). (<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>).
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): ☐ Permanent The patient's disability is: □ 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: _____