Research College of Nursing

Medical Exemption Request & Waiver

Covid-19 Vaccination

Student Information – *To be completed by student*

Printed Name: _____ 3-4 ID: _____

Date: _____ Date of Birth: _____

If you wish to request a medical exemption from vaccination requirement, please sign the waiver below:

_____ (Initial) I understand that the exemption may not be accepted by clinical partners, even if accepted by Research College of Nursing.
_____ (Initial) I understand that if clinical partners do not accept the exemption, I may not attend clinicals at those facilities.
_____ (Initial) I understand that if I cannot complete clinical at my assigned clinical facility, I will not pass the clinical course.
_____ (Initial) I understand that failure to pass the clinical course could result in failure to graduate on time or dismissal from the program.
_____ (Initial) I agree not to hold Research College of Nursing liable or accountable if I am unable to complete clinical courses, including if graduation is delayed or I am dismissed from the program because of the course failure.
_____ (Initial) I understand that without vaccination, I am at increased risk to acquire, and/or transmit disease, which could lead to serious illness or death.

Printed Name:_____ Date:_____

Signature:_____

Healthcare Provider Information – *To be completed by healthcare provider*

Printed Name: _____ Provider Specialty: _____

NPI: _____ Phone Number: _____

Licensed Healthcare Provider: Please mark the contraindications / precautions or other medical condition / disability that apply to this patient and sign and date this form. Licensed Healthcare Provider must include either a treating physician (M.D. or D.O.) or treating advanced practice professional (nurse practitioner or physician assistant). **Note: Health Care Providers cannot sign their own exemption / certification request.**

Vaccine Contraindication Certification (list all that apply) – ***Requires healthcare provider signature*** **Note – Contraindication to one vaccine does not preclude receipt of another vaccine type**	
Johnson & Johnson	☐ Known history of severe allergic reaction (anaphylaxis) to any component of the vaccine or immediate allergic reaction ☐ Previous history of heparin-induced thrombocytopenia (HIT)

	☐ History of Guillain-Barre Syndrome postvaccine ☐ Contraindication to MRNA vaccines (must specify below) AND female under age of 50 ☐ My patient has a physical or mental impairment that substantially limits one or more major life activities and prevents the patient from safely receiving the vaccine. (More detail regarding the medical condition and how it prevents the patient from receiving the vaccine must be attached). Additional Information:
mRNA Pfizer or Moderna	☐ Known history of severe allergic reaction (anaphylaxis) to any component of the vaccine or immediate allergic reaction ☐ Known history of severe reaction (anaphylaxis) to the first dose of either mRNA vaccine ☐ Previous history of Multisystem Inflammatory Syndrome (MIS) of adults or children ☐ Documented Myocarditis after first dose of mRNA vaccine ☐ My patient has a physical or mental impairment that substantially limits one or more major life activities and prevents the patient from safely receiving the vaccine. (More detail regarding the medical condition and how it prevents the patient from receiving the vaccine must be attached). Additional information:

I attest that I have a healthcare provider-patient relationship with the employee identified above and that the above statements are true and accurate.

Healthcare Provider Signature: _____ Date: _____

For internal use only:
(Post-initial review)
This form is:

☐ Complete
☐ Incomplete

Internal review date (if applicable): _____

Comments:

Completed forms must be submitted to the Dean at Rebecca.Saxton@researchcollege.edu.