COVID-19 Vaccine Medical Exemption Request Form

Cox College Student Form (Attachment B)

Cox College Student Section: **Complete the following information**

Name: _____

Email Address: _____ **Best Phone Number:** _____

Submit completed Attachment A and Attachment B to employeehealth@coxhealth.com. Requests for exemptions will be kept confidential and shared only with those who need to know.

I authorize my healthcare provider to release information to and, if necessary, speak with CoxHealth about my medical condition for the purpose of evaluating this exemption request.

Signature: _____

Healthcare Provider Section: **A licensed Physician, PA, or NP must complete and sign this section.**
Forms completed by the Cox College student requesting exemption will not be accepted.

Provider Instructions: CoxHealth requires students rotating at CoxHealth to receive the COVID-19 vaccine. Your patient is requesting a medical exemption from receiving the COVID-19 vaccine. Medical exemptions may be granted for recognized contraindications. Guidance for medical contraindications for COVID-19 vaccination can be obtained from the Advisory Committee on Immunization Practices (ACIP) available at https://www.cdc.gov/vaccines/covid- 19/info-by-product/clinical-considerations.html.

The following are not considered contraindications to COVID-19 vaccination:

- Local injection site reactions after (days to weeks) previous COVID-19 vaccines (erythema, induration, pruritus, pain, etc.)
- Expected systemic vaccine side effects in previous COVID- 19 vaccines (fever, chills, fatigue, headache, lymphadenopathy, vomiting, 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 vaccines, including injectable therapies, food, pets, venom, environmental allergens, oral medication, latex, etc. Please note the COVID vaccines do not contain egg orgelatin.
- Immunosuppressed person in the healthcare worker's household
- Family member or household member who falls into a medically exemptcategory

Please select medically indicated contraindication below:

☐ Temporary: Active COVID-19 infection Date of positive test result: _____

☐ Temporary: Recently received a COVID-19 monoclonal antibody therapy (mAb). Date of therapy: _____

☐ Severe allergy to the vaccine or vaccine component. Please describe in detail the previous allergic reaction and the contraindication to alternatives (if the patient is allergic to a component of a COVID-19 vaccine):

_____

_____

_____

☐ Other medical circumstance preventing vaccination with any available COVID-19 vaccine. Describe in detail:

_____

_____

_____

_____

It is my opinion that my patient referenced above has the COVID-19 vaccine contraindication as identified.

Signature of Provider: _____ **Date**: _____

Printed name: _____ **Practice name**: _____

Practice telephone number: _____ **Practice email:** _____