**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 [Emily.Harrington@coxhealth.com](mailto:Emily.Harrington@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 h[ttps://www.cdc.gov/vaccines/covid- 19/info-by-product/clinical-considerations.html.](http://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 exempt category

# 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:**