COVID-19 VACCINE MEDICAL EXEMPTION PROVIDER FORM

Printed Name _____ GVSU Email _____ G# _____

Please have a health care provider (MD, DO, NP, PA) who has knowledge of your medical history and who has treated you for the condition that you are requesting the exemption for, complete the information below.

Provider: Please note the vaccine contraindication or other medical condition(s) that prevent the individual from receiving any COVID-19 vaccine at this time.

VACCINE CONTRAINDICATION (Contraindication to one vaccine does not preclude receipt of another vaccine type) **Attach clinical documentation providing specifics for the vaccine contraindication checked below**	
Janssen/ Johnson & Johnson	○ History of severe allergic reaction (anaphylaxis) to any ingredient in vaccine ○ History of heparin-induced thrombocytopenia (HIT) ○ Contraindication to mRNA vaccines (as noted below) AND female under the age of 50 ○ Other
mRNA Vaccine Pfizer or Moderna	○ History of severe allergic reaction (anaphylaxis) to any ingredient in mRNA vaccine ○ History of severe allergic reaction (anaphylaxis) to first dose of either mRNA vaccine ○ Other

DEFERRAL – Requires estimated date for receipt of vaccine **Attach clinical documentation providing specifics for the deferral reason checked below.**	
Deferral Reason	**Estimated Date Vaccine to Be Received**
○ Currently pregnant	
○ History of Multi-system Inflammatory Syndrome (MIS) of adults or children	
○ History of Myocarditis following first dose of mRNA vaccine	
○ Receipt of monoclonal/polyclonal COVID-19 antibody treatment within the past 90 days	
○ Receipt of high titer COVID-19 convalescent plasma within the past 90 days	
○ Other	

I attest that I have a health care provider/patient relationship with the individual who has requested an exemption to all of the current COVID-19 vaccines, and that the statements above, and on the clinical information attached, are true and accurate.

Printed Name: _____License (or MRN) # _____

Signature: _____ Date _____

Name of Practice: _____Phone number: _____

Address: _____

Street City State Zip

NOTE: Exemptions will minimally require annual review. The university may request review on an earlier timeframe based upon updated clinical criteria or new vaccine information. Deferrals will be provided for a specified timeframe.