FREDONIA
STATE UNIVERSITY OF NEW YORK

COVID 19 Vaccine Medical Exemption Form

Section I: Student Information (to be completed by student or guardian, if student is under 18)

Last Name	First Name	Student Email	Date of Birth	Fredonia ID#

Signature:_____ **Date:** _____

Student or guardian if under 18

Section II: Medical Exemption Request (to be completed by medical provider)

Information will be reviewed by our physician.

Medical Exemption: See the CDC guidance regarding contraindications for COVID-19 vaccines.

Medical Provider Certification of Contraindication: I certify that my patient (named above) cannot be vaccinated against COVID-19 because of the following contraindication:

☐ Documented immediate (< 4 hours) or severe allergic reaction/anaphylaxis (e.g., hives, swelling of the mouth or throat, difficulty breathing, low blood pressure, or shock) after receiving a COVID vaccine or to any of the vaccine components**:**
Provide the name of the vaccine or the vaccine component and describe the reaction.

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_____

☐ History of thrombosis with thrombocytopenia.
Please explain, including date of diagnosis and presentation/complications.

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_____

☐ History of Multisystem Inflammatory Syndrome in Children (MIS-C) or Adults (MIS-A) after a confirmed SARS-CoV-2 infection or a COVID-19 vaccine.
Please explain, including date of diagnosis and manifestations/complications.

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☐ I understand that if I am not fully vaccinated against COVID-19, I will need to abide by all COVID-19 related health and safety restrictions if accessing a SUNY facility, including, but not limited to, use of face masks, physical distancing, participation in surveillance testing, and quarantine.

Healthcare Provider Information	Date
Name (print):	Address/Clinic Stamp:
Signature:	Phone:

Once completed, students email this form to the Student Health Center at health.center@fredonia.edu.
Uploaded exemption request forms will be reviewed. Decisions will be released through the Secure Messaging function of the Health Services' portal.