UNIVERSITY OF MARYLAND GLOBAL CAMPUS

COVID-19 Vaccination

MEDICAL EXEMPTION REQUEST FORM

(To be completed by physician)

If you have an allergy to COVID-19 vaccine or a specific medical condition that precludes the COVID-19 vaccination requirement and you seek a medical exemption from the USM and UMGC's COVID-19 vaccination requirement, please consult with your physician and provide the following information. Request for exemptions and any documents provided will be kept confidential and shared only with those university appointees who have a need to know.

FOR THE REQUESTOR (Student)

I verify that the information provided is complete and accurate to the best of my acknowledge, and I understand that any intentional misrepresentation contained in this request may result in disenrollment of hybrid classes. I also understand that my request for an exemption may be denied if this form is incomplete or additional information is required to support my request.

Print Name: _____ *Date:* _____

Student ID No.: _____ *Email:* _____

FOR THE LICENSED PHYSICIAN

Dear Physician:

A mandatory COVID-19 vaccination policy is in effect across the University System of Maryland schools, that requires COVID-19 vaccinations for all students, faculty and staff seeking access to UMGC designated campus sites. A medical exemption from COVID-19 vaccination is allowed for certain recognized contraindications **https://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html**

Please complete the form below on behalf of the requestor. Should you have any questions, please contact accessibilityservices@umgc.edu or call 240-684-2287.

QUESTIONS TO HELP DETERMINE WHETHER AN EXEMPTION IS NEEDED

The individual listed above should not be immunized for COVID-19 for the following reasons:

(Please check all that apply):

☐ *Severe allergic reaction (e.g anaphylaxis) after a previous dose or to a component of the COVID-19 vaccine*

☐ *Immediate allergic reaction of severity to a previous dose or known (diagnosed) allergy to a component of the vaccine (Vaccine Ingredients:* **https://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html#Appendix-C)**

Which ingredient caused an allergic reaction?

What was the reaction?

Which brand of the COVID-19 vaccine is contraindicated and why?

How long will the medical contraindication last?

☐ *The physical condition of the person or medical circumstances relating to the person are such that immunization is not considered safe.*

Please indicate the specific nature and probable duration of the medical condition or circumstances that contraindicate immunization with COVID-19 vaccine.

☐ *Other Medical Reason: Please describe the other medical reason and justification of why the exemption is necessary.*

I certify that _____ has the above contraindication or specific medical condition and request a medical exemption from COVID-19 vaccination.

Physician Signature: _____ **Date:** _____

Physician Medical License No. _____

Clinic Name: _____ **Phone No.** _____