

# Shawnee State University

## COVID-19 Student Vaccination Exemption Request

Internship sites, clinical sites and/or health systems in which SSU students are placed for experiential training may require full vaccination against COVID-19 while some sites may accept a vaccination-related exemption.

To request an exemption for medical reasons or sincerely held religious beliefs, you must complete the appropriate sections of this form and submit to SSU Accessibility Services/Health Team at [mboldman@shawnee.edu](mailto:mboldman@shawnee.edu) prior to reporting to your placement site. Exemption requests will be considered on an individual basis.

Student Name: \_\_\_\_\_ SSU ID: \_\_\_\_\_

Student Email: \_\_\_\_\_ Student Phone: \_\_\_\_\_

Program: \_\_\_\_\_ SSU Clinical Coordinator/s: \_\_\_\_\_

Faculty Email/s: \_\_\_\_\_

I authorize the Shawnee State University Office of Accessibility Services and/or SSU Health Team to release information to my SSU Clinical Coordinator and/or Clinical Site as deemed necessary to facilitate this request for exemption.

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Check the circle of **each area** that applies to you.

- I am requesting an exemption from receiving the COVID-19 vaccination based on:
  - Sincerely Held Personal or Religious Belief, Practice or Observance. **Complete Section I.**
  - Medical Reason (Must provide Medical Certification from your healthcare provider). **Complete Section II and Section III.**

All contraindications to the vaccination and support for student requests for medical exemptions must (1) be signed and dated by a licensed practitioner who is not the individual requesting the exemption and who is acting within their scope of practice; (2) identify which of the authorized COVID-19 vaccines are clinically contraindicated for the student and the recognized clinical reasons for the contraindications; and (3) include a statement by the authenticating practitioner recommending that the student be exempted from the vaccination based on recognized clinical contraindications. Providers should refer to the CDC guidance identifying clinical contraindications, Interim Clinical Considerations for Use of COVID-19 Vaccines Currently Approved or Authorized in the United States available at: <https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html>

# COVID-19 VACCINE RELIGIOUS EXEMPTION

## SECTION I

**All sections must be entirely filled out. DO NOT put “see attached” or “as noted”.**

If you seek a religious exemption:

a. What are your basic beliefs?

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b. Describe how your religion, strongly held religious belief, or practices/observations affect your ability to receive a COVID-19 vaccine.

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Please provide and/or attach any additional information that you believe might be useful as we consider your request. Depending on the information you provide, we may request additional follow up.

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You will receive a determination by email. Any request granted is conditional and subject to reconsideration based on changing needs, SSU policy, and/or the placement site conditions which may change at any time.

If you have any questions, please do not hesitate to contact SSU Accessibility Services by emailing [mboldman@shawnee.edu](mailto:mboldman@shawnee.edu)

**Special Notice Regarding COVID-19 Vaccinations:** The completion of my program requires a clinical component that takes place off the premises of the Shawnee State University campus. Shawnee State does not currently mandate that students have the COVID-19 vaccination. Further, the University will take reasonable measures to attempt to place students with religious or medical reasons for not being vaccinated at clinical locations that recognize medical and/or religious belief exemptions. However, Shawnee State does not guarantee placement of an unvaccinated student in a clinical location that recognizes such exemptions.

By my signature below, I acknowledge that I have read the Special Notice, above, and I attest that the information in this form, and any subsequent information provided by me as part of this process, is true and correct.

TODAY'S DATE: \_\_\_\_\_

DOB: \_\_\_\_\_

PRINT NAME: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

SSU STAFF NOTES ONLY:

## COVID-19 VACCINE MEDICAL EXEMPTION -- PATIENT/STUDENT SECTION II

Patient/Student Name: \_\_\_\_\_  
First Middle Last

DOB: \_\_\_\_\_ Date Certification Requested: \_\_\_\_\_

*If the reason is medical, you must provide a medical certification timely completed by your health care provider, confirming that you are under their care, and that they are recommending that you not be vaccinated as a result of your medical condition/need, in order for us to consider your request.*

**DO NOT PROVIDE INFORMATION ABOUT GENETIC TESTS, GENETIC SERVICES, OR ANY FAMILY MEDICAL HISTORY.**

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I have read and understand the Special Notice, above.

TODAY'S DATE: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

SSU STAFF NOTES ONLY:

## COVID-19 VACCINE MEDICAL EXEMPTION -- HEALTH CARE PROVIDER SECTION III

**DO NOT PROVIDE INFORMATION ABOUT GENETIC TESTS, GENETIC SERVICES, OR ANY FAMILY MEDICAL HISTORY.**

Your patient has requested an exemption to a COVID-19 vaccination policy at their internship and/or experiential training site. Please provide your contact information, complete the information below, and sign the form. Limit your response to the medical condition(s) for which the individual is seeking an exemption to the COVID-19 vaccination policy. Do not provide information about genetic tests, as defined in 29 C.F.R. 1635.3(f), genetic services, as defined in 29 C.F.R. 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. 1635.3(b).

Health Care Provider's name: (Print): \_\_\_\_\_

Health Care Provider's business address: \_\_\_\_\_

Type of practice / Medical specialty: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

The individual listed in Section II of this form is currently my patient and under my professional medical care:

- Yes
- No

Please indicate below if your patient has a verifiable medical contraindication to receiving the COVID-19 vaccine. Please note that the currently available U.S. COVID-19 vaccines do not contain Thimerosal, eggs, antibiotics, or latex. Please check one of the following:

- Documented personal history of a severe allergic reaction (e.g., anaphylaxis) to a previous dose or component of a COVID-19 vaccine. Please indicate the specific vaccine and date of reaction:

COVID-19 Vaccine name: \_\_\_\_\_ Date: \_\_\_\_\_

Describe reaction: \_\_\_\_\_

- Documented personal history of an immediate allergic reaction of any severity (such as urticaria, angioedema, respiratory distress within 4 hours following injection) to a previous dose or component of a COVID-19 vaccine. Please indicate the specific vaccine/vaccine component and date of reaction:

COVID-19 Vaccine Name: \_\_\_\_\_ Date: \_\_\_\_\_

Describe reaction: \_\_\_\_\_

Polysorbate, Describe: \_\_\_\_\_

Polyethylene Glycol (PEG), Describe: \_\_\_\_\_

Other Vaccine Component: Describe: \_\_\_\_\_

- Other - Describe in specific detail the medical contraindication that would make receiving the COVID-19 vaccine unsafe, if not due to previous severe adverse reaction to a COVID-19 vaccine or one of its components. Please provide any citations to scientific evidence to be considered and provide detailed medical information regarding your patient related to the contraindication. This must be filled out by the treating physician:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- Due to his/her disability/medical condition, I am recommending:  
that my patient not receive a COVID-19 vaccination

Signature of Health Care Provider: \_\_\_\_\_ Date: \_\_\_\_\_

