Student Application for Medical Exemption from COVID-19 Vaccine

INSTRUCTIONS:

1. This form must be completed by any student who is requesting a waiver from the University requirement for a COVID-19 vaccine, or by the parent of such a student, if the student is under age 18.
2. The request of a waiver may only be made on medical grounds.
3. This form must be submitted through the University's MyHealth Portal.

Related Policies:

1. Refer to Current COVID-19 Policy
2. COVID outbreak: the university may require exempted students to remain off campus until the outbreak is over.
3. This form is valid only for the COVID-19 vaccine. **It is not an exemption for COVID testing**.
4. Approved waivers are valid for one academic year. A new waiver request must be submitted for each subsequent academic year (or upon expiration date).

Last Name: ________________________________ First Name: ______________________________

CWID: __________________________________ Cell Phone: _______________________________

Current age: ___________________ Date of Birth Month: _______ Day: ________ Year: __________

Must completed by a U.S. licensed physician, nurse practitioner, physician assistant familiar with treating the student:

Check all that apply	**CDC Contraindications:**
	Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a component of the COVID-19 vaccine. **Please attach supporting documentation.** **Date of vaccine**:
	Immediate (within 4 hours of exposure) allergic reaction of any severity to a previous dose or known (diagnosed) allergy to a component of the vaccine. **Please attach supporting documentation.** **Date of vaccine:**

Incomplete or unsigned form will not be processed

Signature of Student: ____________________________________ **Date**:____________________

Signature of Parent/Guardian if student under age 18: ________________________________ **Date:** ____________

By signing below, I affirm that I have reviewed the current CDC contraindications and precautions for the required vaccines, including the Covid-19 vaccine. I understand that I might be required to submit supporting medical documentation. I also understand that any misrepresentation might result in referral to the NJ State Board of Medical Examiners and/or appropriate licensing/regulatory agency

Medical Provider Name (print) **Signature** **Date**

State of licensure _________ **License #** ____________________

OFFICE STAMP (REQUIRED):

04/2022