UNIVERSITY OF MARYLAND

UMD REQUEST FOR MEDICAL EXCEPTION FROM COVID-19 VACCINATION

Please print the following information:

Name:_____ Date of Birth: _____

E-mail:_____ Phone No.:_____

Department/School:_____ Supervisor(Faculty/Staff):_____

Physician Name:_____ Physician Phone No.:_____

Physician Address:_____

Instructions: Please give this form to your physician to complete and sign. After your physician has completed and signed the form, please complete, sign and date the attestation at the bottom.

FOR THE LICENSED PHYSICIAN

Dear Physician:

A mandatory COVID-19 vaccination policy is in effect across the University of Maryland. The above named person is requesting an exception from this vaccination requirement. A medical exception 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. Should you have any questions, please contact the University Health Center at (301) 314-8180 or health@umd.edu. Thank you.

The above person 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 any 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?

_____

How long will the medical contraindication last? Please specify date_____

Has the patient seen an Allergist?_____

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☐ The physical condition of the person or medical circumstances relating to the person are such that immunization is not currently considered safe. **Please attach a separate statement that describes the medical reason justifying an exception in detail, indicating the specific nature and probable duration of the medical condition or circumstances that contraindicate immunization with the COVID-19 vaccine.**
You may fax this form directly to the University Health Center at (301) 314-5234 or return it to the patient.

I certify that_____has the above contraindication(s) and request a medical exception from the COVID-19 vaccination.

Physician Signature:_____(Note: Signature Stamp Not Acceptable)

Date:____/_____/_____License No:_____State or Country_____

FOR THE REQUESTOR (Student/Faculty/Staff)

I attest that the above information is complete and accurate to the best of my knowledge, and I understand that any intentional misrepresentation contained in this request could result in progressive disciplinary action, up to and including suspension and termination for faculty and staff and suspension and expulsion for students.. I also understand that my request for an exception may not be granted if it creates an undue hardship for the University.

Signature:_____Date: _____
Name (please print): _____
UID No.:_____

Signature of Parent or Guardian (if <18 years old) _____
Print Name:_____Date: _____

PLEASE SUBMIT THIS FORM AND THE ATTACHED STATEMENT TO THE UNIVERSITY HEALTH CENTER BY VISITING MYUHC.UMD.EDU AND FOLLOWING THESE STEPS:

- Click on Forms, then click Immunizations
- Click on Add Immunization Form and upload your documentation
- Click Submit Final

DESIGNATED OFFICE USE ONLY:
Medical Exception Approved on:__/__/__Approving Staff Signature: