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?________________

☐ 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 AN ELECTRONIC COPY OF THIS ENTIRE FORM TO THE UNIVERSITY HEALTH CENTER BY VISITING MYUHC.UMD.EDU AND FOLLOWING THESE STEPS:

- Click on Downloadable Forms.
- Find the section for COVID-19 Vaccine Medical Exemption Request.
- Click Upload.

DESIGNATED OFFICE USE ONLY: Medical Exception Approved on:___/___/___Approving Staff Signature: