ST. JOHN FISHER COLLEGE

Request for Medical Exemption from Vaccination and/or Booster

Student Name:_____ SJFC ID#@:_____

Date of Birth:_____ SJFC email address:_____

Major:_____ Alternate email address:_____

Cell phone number:_____

This request is for: ☐ vaccination ☐ booster

This request is for: ☐ an extension to the due date ☐ a complete exemption

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St. John Fisher College (the "College") requires that all students attending classes on campus be fully vaccinated and boosted against the following communicable diseases:

- Measles, Mumps and Rubella (MMR)
- Meningitis (MenACWY) - *Residential students only. Others may waive this requirement.*
- Covid-19 (SARS-CoV-2)

Note: Nursing and Pharmacy students have additional vaccination requirements.

The College recognizes certain exceptions to this requirement, including specifically an exemption for those with underlying medical conditions that prevent them from being vaccinated against one or more illnesses. This form is for your use in applying for such a medical exemption to one or more of St. John Fisher College's above immunization requirements. Its purpose is for the Medical Provider (MD, DO, NP or PA) licensed in New York State caring for a student, not related to the student, whose specialty is appropriate to the associated medical condition, to certify in writing that a student has a health condition which is a valid contraindication to receiving a specific vaccine. This statement must specify those immunizations which may be detrimental and the length of time they may be detrimental.

The College will carefully review all requests for medical exemptions, however, approval is not guaranteed. After your request has been reviewed and processed, you will be notified in writing to your SJFC email address, as to whether an exemption has been granted or denied.

Medical Exemption Process:

1. If requesting an exemption from all COVID-19 vaccines, read the CDC COVID-19 Vaccine Information
2. Read and initial all statements in Section 1
3. Verify through signing and notarizing in Section 2
4. Have your Licensed Health Care Provider complete the Certification of Licensed Health Care Provider form in Section 3
5. Submit all completed documents to the College electronically: https://forms.gle/MhZuCvBjJ8S7a9kR9

Incomplete submissions will not be reviewed - be sure all forms and documentation are submitted at one time.

For Questions: Please contact Health and Wellness Center at healthcenter@sjfc.edu or (585) 385-8280

Section 1: *To be completed by student (or parent/guardian if the student is under 18) if requesting exemption from COVID-19 vaccine.*

Affidavit of Medical Exemption to all COVID-19 Vaccinations

1. I understand that St. John Fisher College requires all students and employees to be fully vaccinated and boosted against COVID-19 and to provide documented proof of same.

2. I sincerely certify that my underlying medical conditions prevents me from receiving all COVID-19 vaccines and that my objections to this vaccination are not based solely on grounds of personal concerns, preferences, or beliefs; or inconvenience; or intellectual beliefs or philosophy.

3. I understand that by *initialing* each statement below I certify that each statement is true and accurate, and I accept the conditions set forth:

_____I request exemption or extension from immunization requirements due to my current underlying medical condition. I understand the risks of non-immunization. I accept full responsibility for my health, and hereby release and agree to hold the College harmless from, and waive on behalf of myself, my heirs, and any personal representatives, any and all causes of actions, claims, demands, damages, costs, expenses, and compensation for damage that may be caused to on account of my objection to receiving the required immunizations.

_____I understand in the event of an outbreak or threatened outbreak, I may be temporarily excluded from classes, residence halls, and any sponsored activities on campus. I agree to comply with these restrictions and accept responsibility for communicating with my faculty and advisors. I further understand that restrictions from campus, including but not limited to classes and living spaces, do not entitle me to any reduction in tuition, housing charges, or other College fees.

_____Should I contract COVID-19, I will report it immediately to SJFC Health and Wellness Center and comply with isolation and quarantine procedures specified by the College.

_____I understand and agree to comply with and abide by all SJFC Health and College policies and procedures.

_____I understand that this request is only valid for the current academic year, and I will need to resubmit the request for any subsequent academic year(s).

_____I certify that the information I have provided on and in connection with this request is accurate and complete. I understand, if this exemption is approved, it may be revoked, and I will be subject to appropriate disciplinary action if any of the information I provided in support of this exemption is false.

_____I authorize my licensed health care provider to provide St. John Fisher College with personal health information about my medical condition related to this request for exemption from COVID-19 vaccination and to provide the College with a Certification of Licensed Health Care Provider. I acknowledge that I may be required to provide additional medical documentation in support of my request for medical exemption.

Section 2: *To be completed by student (or parent/guardian if the student is under 18) and notary public.*

Please sign in the space provided below and have the document notarized by a notary public where indicated.

I affirm that my Affidavit of Medical Exemption to all COVID-19 Vaccinations and all information in my Request for Medical Exemption from COVID-19 Vaccine form are true, accurate, and complete, and that I have a medical condition that is a contraindication to all COVID-19 vaccinations.

I acknowledge that false statements intentionally made herein may result in this exemption being revoked, and I may be subject to appropriate disciplinary action through Student Conduct, including suspension or expulsion from the College without refund.

Student Name (print):_____ SJFC ID#@:_____

Signature:_____ Date:_____

Sworn to me this: ***Notary Public Seal***	**Day of**

(For Minors only)

Parent/Guardian Name (print):_____ Phone:_____

Signature:_____ Email:_____

Date:_____

Section 3: *To be completed by Medical Provider*

Certification of Licensed Health Care Provider for Request for Medical Exemption from Vaccination

My patient, _____, is submitting a request for a medical exemption from St. John Fisher College's vaccination requirement(s).

In support of that medical exemption, my patient voluntarily requests and authorizes me to prepare this Form, and to provide the College with personal health information about the patient's medical condition(s) related to this request, including supporting documentation regarding the medical reason that vaccination is contraindicated to the patient's medical condition(s) that prevent the patient from receiving the vaccine at this time.

Please indicate the vaccine(s) for which the student requires a medical exemption:

- ☐ Measles, Mumps and Rubella Vaccine (MMR) - complete section A
- ☐ Meningococcal Vaccine (MenACWY) - complete section A
- ☐ Covid-19 Vaccine (SARS-CoV-2) – complete section B
- ☐ Other _____

A. To be completed by medical provider if requesting exemption from MMR and/or MenACWY
Please describe or list the medical conditions, events or other reasons for which a medical exemption is being requested (additional pages may be attached):

B. To be completed by medical provider if requesting exemption from or extension for all COVID-19 vaccines or boosters

Option 1 - Allergy

☐ A documented history of a severe allergic reaction to any component of a vaccine or to a substance that is cross-reactive with a component. Please specify the allergic components of **ALL** the following vaccines. **NOTE**: since egg-free COVID-19 vaccine is available, history of an egg allergy will not be accepted as an allergic reaction to a COVID component.

- Moderna - List the allergic component(s):_____
- Pfizer - List the allergic component(s): _____
- Janssen/Johnson & Johnson - List the allergic component(s): _____

☐ A documented history of a severe allergic reaction after a previous dose of the COVID-19 vaccine. Please indicate to which vaccine the patient had a reaction, the date of the vaccine, and the severe reaction:

- Moderna - Date of Vaccine & Reaction: _____
- Pfizer - Date of Vaccine & Reaction: _____
- Janssen/Johnson & Johnson - Date of Vaccine & Reaction: _____

Option 2 - Physical Condition/Medical Circumstance

☐ The physical condition or medical circumstances of the patient that render vaccination unsafe or contraindicate COVID-19 vaccination are as follows (additional pages may be attached):

Probable time the physical condition or medical circumstances is expected to render vaccination contraindicated to COVID-19 vaccination is: _____

Health Care Provider Certification

I certify that the information contained herein is true, accurate, and complete and I support the patient's request for a medical exemption from the COVID-19 vaccine requirement of St. John Fisher College.

Heath Care Provider Name (print):_____

Practice/Specialty:_____ License Number:_____

Address:_____ Email address:_____

Phone number:_____

Provider Signature:_____ Date:_____

Section 4: Submit

Once completed, students should submit all pages of this signed and notarized form to the College electronically: https://forms.gle/MhZuCvBjJ8S7a9kR9

Please note, submitting this request does not guarantee approval. Upon review, you will be notified in writing if the exemption has been granted or denied. At any time, the College reserves the right to request additional supporting documentation. If approved, the exemption will remain in effect for the duration of the current academic year. Requests must be renewed annually.