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**COVID-19 Vaccine Medical Exemption Request Form**

 **Confidential**

Instructions: A request for a medical exemption from the COVID-19 vaccine requirement at Lenoir-Rhyne University may be submitted by a new student or employee. This application should be submitted as quickly as possible, but prior to the first day of class or the employee start date is required. Students will submit their forms online though Dynamic Forms. Employees will submit their form to the Office of Human Resources.

**Please know that applications must be approved and signed by a licensed medical physician. Applications signed by other healthcare providers (physician assistants, nurses, office staff, nurse practitioners, etc.) will not be considered.** It is also recommended the physician be a specialist if addressing a contraindication of the vaccine to a particular medical condition.

**Section I: to be completed by the requestor or guardian (if under 18)**

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| **Requestor Information** |
| Last Name: First Name: MI: |
| LRU ID #: |
| Email Address:  |
| Phone Number:  |

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| Print Name: |
| Signature:*Guardian if under 18*Date: |

**Section II: Medical Exemption Request (to be completed by a licensed physician)**

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| **Physician Information** (may not be related to requestor) |
| Last Name: First Name: MI: |
| Name of practice and discipline of medical practice:  |
| Physician license number:  |
| Email Address:  |
| Phone Number:  |

***Medical Provider Certification of Contraindication: I certify that my patient (as named above) should not be vaccinated against COVID-19 because they have one (or more) of the following contraindications:***

⃣ There is a documented anaphylactic allergic reaction or other severe adverse reaction to any of the three Covid-19 vaccines. Other **severe adverse** reaction includes cardiovascular changes, significant respiratory distress, or history of treatment with epinephrine or other emergency medical attention to control symptoms. This does not include sore arm, local reaction, low grade fever, or subsequent respiratory tract infection or gastro-intestinal symptoms. Please describe the specific reaction, to what vaccine, date, and any other supporting documentation and information.

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⃣ There is a documented allergy to a component of the vaccine. Please note that the COVID-19 vaccine does not contain egg. Provide detailed and specific information related to this component and data to support any negative reaction:

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⃣ There is another well-documented specified medical circumstance that supports the contraindication of the COVID-19 vaccine for this person. Provide detailed and specific information related to this circumstance and contraindication:

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Are any of the above documented statements regarding contraindication(s) supporting exemption from the COVID-19 vaccine considered to be ⃣ Temporary ⃣ Permanent

If temporary how long?

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| Physician’s Signature:Date: |