UNIVERSITY OF St.Thomas

COVID-19 VACCINE MEDICAL EXEMPTION FORM

Name:	St. Thomas ID:	Date of Birth:
Guardian Name (if under age of 18): *first / middle / last*		Primary Phone:
Permanent Home Address: *address 1* *address 2* *city* *state* *zip*		
Personal Email Address:		

Medical contraindications and precautions for immunizations are based on the most recent General Recommendations of the Advisory Committee on Immunization Practices (ACIP)/CDC, available at https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html or https://www.cdc.gov/vaccines/covid-19/index.html or https://redbook.solutions.aap.org/redbook.aspx
Please check the website to ensure that you are reviewing the most recent CDC/ACIP information.
Please note that thepresence of a moderate to severe acute illness with or without fever is a precaution to administration of all vaccines However, as acute illnesses are short-lived, medical exemptions should not be submitted for this indication.

Table 1. ACIP Contraindications and Precautions to Vaccination for Mandatory Vaccines

Vaccine	Exemption Length	ACIP Contraindications and Precautions
COVID19 Vaccine	Temporary through: Permanent	**Contraindications** Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component Other - ***Please describe here***:

Attestation

I am a physician (M.D. or D.O) licensed to practice medicine in a jurisdiction of the United States or an advanced practice nurse licensed in a jurisdiction of the United States.

By signing below, I affirm that I have reviewed the current CDC/ACIP Contraindications and Precautions and affirm that the stated contraindication(s)/precaution(s) is enumerated by the CDC/ACIP and consistent with established national standards for vaccination practices. I understand that I might be required to submit supporting medical documentation

Healthcare Provider Name (please print): _____ Specialty: _____

NPI Number: _____ License Number: _____ State of Licensure: _____

Phone: _____ Fax: _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Signature: _____ Date: _____

***** Please FAX this form to Center for Well-Being (651) 962-6751 or submit through myHealthPortal using Document Upload *****

Center for Well-Being | UNIVERSITY OF St.Thomas