

Binghamton University

COVID-19 Vaccination Medical Exemption Request Form

To request a medical exemption from the SUNY COVID-19 vaccination requirement you should complete Part I, including the demographics section, the acknowledgement checkboxes and the signature. Ask your medical provider to complete Part IIA and/or IIB, and Part IIC, then submit the completed form to the "Uploads" section of the student health portal (<https://binghamton.medicatconnect.com>) using the COVID-19 Medical Exemption link. If the form is uploaded elsewhere on the portal it will not be reviewed. A decision regarding your request will be provided via the Secure Messaging function of the student health portal.

Part I. Student Information and Certification:

FIRST NAME	LAST NAME	STUDENT EMAIL ADDRESS	STUDENT DATE OF BIRTH	STUDENT B-NUMBER

Check each box to acknowledge:

- While my request is pending, I understand that I must comply with the campus's COVID-19 related health and safety protocols (e.g. masks/face coverings, social distancing, regular surveillance testing).
- I certify that I have confirmed with my academic program that not receiving the COVID-19 vaccination will not prevent the completion of my programmatic or curricular requirements.
- If my request is granted, I acknowledge that I will be required to understand and comply with the campus's COVID-19 related health and safety protocols pertaining to unvaccinated or under-vaccinated individuals, including the SUNY COVID-19 Vaccination Policy, which became effective on Sept. 27, 2021. These policies may include the use of face coverings, social distancing and regular surveillance testing for the SARS-CoV-2 virus. Furthermore, I acknowledge that the consequences of not complying with these regulations may include having a hold placed on my ability to register for future courses or being deregistered from current courses.
- I certify that my statements above, and all supporting documentation, are true and accurate and that the receipt of the COVID-19 vaccination may be detrimental to my health.

Signature*: _____

Date: _____

*Student's signature, or parent/legal guardian must sign if the student is under 18 years old as of the first day of classes.

Note that the campus reserves the right to request additional documentation to support a request for a medical exemption.

Part II. Medical Exemption Request (to be completed by medical provider only)

A licensed medical provider (Physician, Physician's Assistant or Nurse Practitioner) and the requesting student should review the CDC guidance regarding contraindications for COVID-19 vaccines. The provider must complete Section(s) A and/or B and provide their contact information in Section C.

By completing this form the medical provider certifies that all methods of vaccinating against COVID-19 have been fully considered and that the student has the contraindication or diagnosis indicated below that precludes any/all available vaccinations for COVID-19 from being administered. Information about approved medical exemptions for COVID-19 vaccination can be found on the Interim Clinical Considerations webpage of the CDC's COVID-19 website.

Part II Section A: Medical Provider Certification of Contraindication or Precaution

I certify that my patient (named above) cannot be vaccinated against COVID-19 because of the following contraindication or precaution. Please select which of the medically indicated COVID-19 vaccine contraindications defined by the CDC apply:

- History of a severe allergic reaction (anaphylaxis; progressive urticaria with wheezing, difficulty breathing, or low blood pressure; angioedema affecting the airway; Stevens-Johnson Syndrome) after a previous dose or to a component of a COVID-19 vaccine.
- History of a known diagnosed allergy to a component of the COVID-19 vaccine. .
- History of an immediate allergic reaction to any vaccine other than COVID-19 vaccine or to any injectable therapy (i.e. intramuscular, intravenous, or subcutaneous vaccines or therapies [excluding subcutaneous immunotherapy for allergies]).
- People with a history of a non-severe, immediate (onset < 4 hours) allergic reaction to a COVID-19 vaccine.

Note that **NONE of the following are considered contraindications** to the COVID-19 vaccine.

- Previous COVID-19 infection.
- Blood test(s) showing evidence of anti-SARS-CoV-2 antibodies.
- Local injection site reactions to previous COVID-19 vaccines (erythema, induration, pruritus, pain).
- Previous mild systemic vaccine side effects to prior COVID-19 vaccines (fever, chills, fatigue, headache, lymphedema, diarrhea, myalgia, arthralgia).
- Vasovagal reaction after receiving a dose of any vaccination.
- Being an immunocompromised individual or receiving immunosuppressive medications.
- Autoimmune conditions, including Guillain-Barre Syndrome.
- Alpha-gal Syndrome.
- Pregnancy, undergoing fertility treatment, intention to become pregnant or breast-feeding. (The American College of Obstetricians and Gynecologists, the Society for Maternal-Fetal Medicine and the Society for Reproductive Medicine all strongly recommend COVID-19 vaccination during pregnancy).
- The medical condition of a family member or other person residing in the same household.

Part II Section B: Medical Provider Certification

I certify that my patient (named above) has the following diagnosis that makes COVID-19 vaccination inadvisable:

- Moderate or severe illness, with or without fever. Diagnosis: _____
- Receipt of passive antibody treatment on (date): _____
- Other (Description): _____

The patient's inability to be vaccinated is:

- Permanent
- Temporary

If temporary, the expected date of eligibility to become vaccinated is: _____

Section C. Medical Provider Information

Provider Name: _____

Provider National Provider Identifier (NPI): _____

Provider Specialty: _____

Provider Employer/Affiliation: _____

Provider Phone: _____

Provider Signature: _____ Date of signature: _____