RIDER UNIVERSITY

REQUEST FOR MEDICAL EXEMPTION FROM COVID-19 VACCINATION

If you have an allergy to the COVID-19 vaccine or a specific medical condition that precludes the COVID-19 vaccination requirement, please consult with your licensed, treating Healthcare Provider (a physician (MD or DO) or nurse practitioner (NP)) and provide the following information:

Name: _____ **Date of Birth:** _____

Rider email: _____ **Cell phone:** _____

BRONC ID: _____

Healthcare Provider Name:_____ **Phone No.:** _____

Healthcare Provider Address: _____

FOR THE HEALTHCARE PROVIDER TO COMPLETE

Dear Healthcare Provider:

Rider University requires COVID-19 vaccinations for all students, faculty and staff seeking access to campus property. A medical exemption from COVID-19 vaccination is allowed for limited recognized contraindications (https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html#Contraindications).

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 and why?

_____

_____

_____

- How long will the medical contraindication last?

_____

_____

☐ Other Medical Reason – Please indicate in the space below or in a separate narrative (as an attachment) the specific nature of the medical condition or circumstances that contraindicate immunization with the COVID-19 vaccine. Precautions to COVID-19 vaccination can be found here on the CDC webpage.

_____

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FOR THE HEALTHCARE PROVIDER - Attestation

I certify that _____ has the above contraindication or specific medical condition and therefore request a medical exemption from COVID-19 vaccination.

By signing below, I affirm that I have reviewed the current CDC contraindications and precautions for COVID-19 Vaccinations. I understand that I might be required to submit additional supporting medical documentation.

Healthcare Provider Name (please print): _____

Specialty: _____

Healthcare Provider Signature:_____

Date: _____
(Note: Signature Stamp Not Acceptable)

License No.: _____ **NPI No.: _____**

State of Licensure: _____

Verification and Accuracy for the Requestor (Student)

I verify that the above information I have provided is complete and accurate to the best of my knowledge, and I understand that any intentional misrepresentation contained in this request may result in disciplinary action which may include suspension or dismissal. My request for an exemption from the COVID-19 vaccination requirement is based upon the medical reason described above. I understand that my request for an exemption may not be granted if it creates an undue hardship for the University.

I understand the risks of non-immunization and have had an opportunity to discuss this with a medical provider. If I am approved for an exemption, I release Rider University, it's employees, directors, representatives, officers, advisors, agents, trustees and lenders from all liability for any resulting injury or illness. I also understand that students whose exemptions are granted for the COVID-19 vaccine will be subject to surveillance testing and other precautionary measures including but not limited to, masking, housing assignment or temporary exclusion from housing or campus in the event of a COVID-19 outbreak or threatened outbreak.

Signature:_____ **Date:_____**

Print Name: _____ **BRONC ID: _____**

Signature of Parent or Guardian (if < 18 years old): _____

Print Name: _____ **Date: _____**

Upload this Form to the Healthy Broncs Portal at
https://rider.medicatconnect.com/