MEDICAL EXEMPTION REQUEST

Students requesting a waiver to the vaccine requirement are REQUIRED to complete this form and submit it to the Dean of Students.

Student Name:_____

Student Email:_____@spalding.edu

Please indicate the immunization you are requesting to waive:

❑ COVID-19

BE ADVISED: Any student with an approved exemption will be required to isolate or quarantine after exposure to or contraction of COVID-19. Remote learning during this time is not guaranteed.

Medical Exemption Request *(to be completed by Healthcare Provider)*

Healthcare Provider Certification of Contraindication and/or Disabling Condition: I certify that my patient (named above) should not be vaccinated because of one of the following contraindications and/or disabling conditions:

[ ] Medical contraindication to vaccination, including but not limited to documented anaphylactic allergic reaction or other severe adverse reaction to any vaccine (e.g., cardiovascular changes, respiratory distress, or history of treatment with epinephrine or other emergency medical attention to control symptoms; generally not including gastro-intestinal symptoms as the sole presentation of allergic reaction) or documented allergy to a component of the vaccine (generally not including sore arm, local reaction, or subsequent respiratory tract infection). Please list the contraindication.

_____

_____

_____

Signature of Healthcare Provider

Printed Name: _____ State License #: _____

Signature: _____ Phone: _____

Clinic Address: _____ Date: _____