Student Medical Exemption Request

PURE NURSING

Student Name:_____ **Birthdate:**_____

Address:_____ **Telephone:**_____

City:_____ **State:**_____ **Zip:**_____ **Student ID:**_____

If you wish to request a medical exemption from a required vaccination, please sign the attestation below:

I have a medical condition or disability that prevents me from taking any of the COVID-19 vaccines authorized by the FDA. To be eligible for this exemption, I understand that I must provide to my school a written statement signed by my licensed healthcare provider, that I qualify for the exemption and indicating the probable duration of my inability to receive the vaccine (or indicating that the duration is unknown). An approved Medical Exemption by the College does not guarantee clinical placement and may result in the inability to be placed in current or future clinical settings. Failure to be placed in a clinical may result in failure to meet course requirements, which could result in program dismissal.

Signature: _____ Date: _____

Healthcare Provider Information – To be completed by healthcare provider

Licensed Healthcare Provider: Please mark the contraindications / precautions or other medical condition / disability that apply to this patient and sign and date this form. Licensed Healthcare Provider must include either a treating physician (M.D. or D.O.) or treating advanced practice professional (nurse practitioner or physician assistant).

Vaccine Contraindication Certification (list all that apply) – Requires healthcare provider signature

Medical exemption related to_____for the following vaccine(s):

_____dTap/Tdap _____Influenza _____Varicella

_____Hepatitis _____ MMR _____COVID-19

For Covid 19 Contraindications only.
Note – Contraindication to one vaccine does not preclude receipt of another vaccine type

Johnson & Johnson

- ☐ Known history of severe allergic reaction (anaphylaxis) to any component of the vaccine or immediate allergic reaction
- ☐ Previous history of heparin-induced thrombocytopenia (HIT)
- ☐ History of Guillain-Barre Syndrome post- vaccine
- ☐ Contraindication to MRNA vaccines (must specify below) AND female under age of 50

- ☐ My patient has a physical or mental impairment that substantially limits one or more major life activities and prevents the patient from safely receiving the vaccine. (More detail regarding the medical condition and how it prevents the patient from receiving the vaccine must be attached).

Additional Information:

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mRNA - Pfizer or Moderna

- ☐ Known history of severe allergic reaction (anaphylaxis) to any component of the vaccine or immediate allergic reaction
- ☐ Known history of severe reaction (anaphylaxis) to the first dose of either mRNA vaccine
- ☐ Previous history of Multisystem Inflammatory Syndrome (MIS) of adults or children
- ☐ Documented Myocarditis after first dose of mRNA vaccine

- ☐ My patient has a physical or mental impairment that substantially limits one or more major life activities and prevents the patient from safely receiving the vaccine. (More detail regarding the medical condition and how it prevents the patient from receiving the vaccine must be attached).

Additional information:

Deferral Certification – Requires healthcare provider signature

General (Request for Deferral)

- ☐ Acute COVID-19 infection documented in the past 90 days
- ☐ Receipt of monoclonal/polyclonal COVID-19 antibody treatment within the past 90 days
- ☐ Receipt of high titer COVID-19 antibody treatment (Convalescent Plasma) within the past 90 days

*Deferral timeframe needed from provider for when student can receive vaccination.
*Date student can be vaccinated: _____
Additional information:

I certify that the physical condition of_____to be such that the inoculation(s) specified on this form would seriously endanger the life or the health of this individual. This individual has been educated on the risk of illness without obtaining specified inoculations.

I attest that I have a healthcare provider-patient relationship with the employee identified above and that the above statements are true and accurate.

Signature:_____Date: _____

Name:_____Provider Specialty:_____

Street Address: _____

City:_____State:_____Zip Code:_____

Telephone: _____

Provider License Number:_____State of License:_____

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