REQUEST FOR MEDICAL EXEMPTION FROM EASTERN'S COVID-19 VACCINATION REQUIREMENT

Students first and last name: ____

Students date of birth: ____

Student ID: ____

As the primary care provider, I am requesting that this patient have a medical exemption pertaining to the COVID-19 vaccine. It is my professional opinion that the patient has an underlying medical condition for which the ***vaccination is contraindicated or the risk of vaccination far outweighs the benefit***.

Reason for Medical Exemption: ____

This exemption will likely be:

____ Permanent ______ This exemption is temporary until: _______________

Print name of health care practitioner: ____

Telephone number: _________________________________

Signature of health care practitioner: ___________________________ Date: _____________________

Individuals with an approved medical exemption may be instructed to wear masks at all times indoors, subjected to testing, remain off campus during a disease outbreak and/or be expected to quarantine. If this were to occur, the College/University with not refund tuition, fees, housing costs or other expenses for the students who must leave campus or quarantine.

Student Signature: ____

Parent Signature (if under 18 years of age): ____

Student ID number: ____________________________

Please fax to Eastern Connecticut State University Student Health Services**. 860- 465- 4560**