

**SUNY Brockport**

**COVID-19 Vaccination Requirement  
Medical Exemption Request Form**

To request a medical exemption from the SUNY COVID-19 Vaccination requirement, please complete this form and upload it to the MyHazen Portal (instructions below). A decision regarding your request will be communicated via email.

**Instructions on How to Submit a Medical Exemption**

1. Login to MyHazen with your NetID & password
2. Go to the "Upload" tab
3. From the drop down menu, select "COVID 19 Medication Exemption Letter", then click "Select File."
4. Attach this file, then click "Upload."
5. Scroll to the bottom of the page to view the document

**Part I. Student Information and Certification:**

LAST NAME	FIRST NAME	STUDENT EMAIL ADDRESS	DATE OF BIRTH	STUDENT ID #

**Please check each box to acknowledge:**

While my request is pending, I understand that I must comply with the campus' COVID-19 related health and safety protocols (e.g., masks/face coverings, social distancing, regular surveillance testing) applicable to unvaccinated or partially vaccinated individuals as a condition of my physical presence in a SUNY Facility.

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 understand that I will be required to comply with the campus' COVID-19 related health and safety protocols (e.g., mask/face coverings, social distancing, regular surveillance testing) if accessing a SUNY Facility as a condition of my on-going physical presence. I am aware that should a COVID-19 outbreak occur at the campus that I may be excluded from all in-person classes and activities and that if I am enrolled in courses that require a physical presence on campus that I may not be able to complete my academic coursework remotely. I acknowledge that any refund I might be entitled to in the case of a COVID-19 outbreak would be subject to all existing SUNY policies.

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, but Parent or Legal Guardian must sign if the student is under 18 years old as of first day of classes.

*Please 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)**

A licensed medical provider (Physician, Physician’s Assistant, or Nurse Practitioner) and 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 provider information in Section C.

**Section A. Medical Provider Certification of Contraindication:** I certify that my patient (named above) cannot be vaccinated against COVID-19 because of the following contraindication:

Please select which of the medically indicated COVID-19 vaccine contraindications defined by the CDC apply:

- Severe allergic reaction (anaphylaxis) after a previous dose or to a component of the COVID-19 Vaccine, including Polyethylene Glycol (PEG). (*Describe reaction/response below and contraindication to alternative vaccines.*)
- Immediate allergic reaction to previous dose or known (diagnosed) allergy to a component of the vaccine. (*Describe reaction/response below and contraindication to alternative vaccines.*)

Additional details on the selected option(s) above (to be completed by the medical provider):

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

- Local injection site reactions to previous COVID-19 vaccines (erythema, induration, pruritus, pain).
- Expected systemic vaccine side effects in previous COVID-19 vaccines (fever, chills, fatigue, headache, lymphedema, diarrhea, myalgia, arthralgia).
- Previous COVID-19 infection.
- Vasovagal reaction after receiving a dose of any vaccination.
- Being an immunocompromised individual or receiving immunosuppressive medications.
- Autoimmune conditions, including Guillain-Barre Syndrome.
- Allergic reactions to anything not contained in the COVID-19 vaccine, including injectable therapies, food, pets, oral medications, latex etc. (Please note the COVID vaccine does not contain egg or gelatin).
- Alpha-gal Syndrome.
- Pregnancy, undergoing fertility treatment, intention to become pregnant or breast-feeding. (Please note 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 residing in the same household as the employee.

Clinician Certification: **By completing this form, you certify that different methods of vaccinating against COVID-19 have been fully considered and that the patient has the contraindication indicated above that precludes any/all available vaccinations for COVID-19.** Information about approved medical exemptions for COVID-19 vaccination can be reviewed at <https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html>

**Section B. Medical Provider Certification of Disability That Makes COVID-19 Vaccination Inadvisable**

*“Disability” is defined as any impairment resulting from anatomical, physiological, genetic, or neurological conditions which prevents the exercise of a normal bodily function or is demonstrable by medically accepted clinical or laboratory diagnostic techniques and any other condition recognized as a disability under applicable law.*

*“Disability” may include pregnancy, childbirth, or a related medical condition where reasonable accommodation is medically advisable.*

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

\_\_\_\_\_

Additional details on why the disability listed above makes COVID-19 Vaccination Inadvisable (to be completed by the medical provider):

\_\_\_\_\_

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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

The patient’s disability is:       Permanent  
   Temporary

If temporary, the expected end date 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: \_\_\_\_\_