

State University of New York at Geneseo

COVID-19 Vaccination/Booster Requirement  
Medical Exemption Request Form

To request a medical exemption from the SUNY COVID-19 Vaccination/Booster requirement, please upload the form to your health portal at <https://myhealth.geneseo.edu> in the left sidebar under Upload/Download Forms.

Exemption requests are evaluated on a case-by-case basis. All requests for exemptions must be submitted **no later than Wednesday, January 12, 2022**. Submissions will be considered within 10 business days. Students must use the forms below. Requests not submitted on these forms will not be considered.

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

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

**Please check each box to acknowledge agreement to each statement:**

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/Booster 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/Booster 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 the 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/booster 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/booster. ▪
- Local injection site reactions to previous COVID-19 vaccines (erythema, induration, pruritus, pain).
  - Expected systemic vaccine side effects in previous COVID-19 vaccines/booster (fever, chills, fatigue, headache, lymphedema, diarrhea, myalgia, arthralgia).
  - Previous COVID-19 infection.
  - Vasovagal reaction after receiving a dose of any vaccination/booster.
  - 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/booster during pregnancy).
  - The medical condition of a family member or other residing in the same household as the student.

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/boosters for COVID-19.** Information about approved medical exemptions for COVID-19 vaccination/booster 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/Booster 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/Booster inadvisable:

\_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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: \_\_\_\_\_