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 under medical forms, Medical Exemption. Exemption requests are evaluated on a case-by-case basis. 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):

_____

_____

_____

_____

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 breastfeeding. (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 or ☐ Temporary If temporary, the 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: _____