

## **Request for Medical COVID-19 Immunization Exemption Form**

Name: \_\_\_\_\_

ID#: \_\_\_\_\_ Email: \_\_\_\_\_ Phone: \_\_\_\_\_

SVA is committed to fostering a safe environment for all community members while providing equal education and employment opportunities without regard to any protected status. With respect to the COVID-19 vaccine, SVA complies with all laws protecting individuals with disabilities, medical conditions and sincerely held religious beliefs. When requested, the school will provide an exemption/reasonable accommodation for any known medical condition, disability or sincerely held religious belief which prevents the faculty member or employee from receiving a COVID-19 vaccine, provided the requested accommodation is reasonable and does not create an undue hardship for the school or pose a direct threat to the health or safety of its community members.

Medical exemptions expire when the medical condition(s) contraindicating COVID-19 immunization changes in a manner which permits immunization, the student to safely return to campus activities, or upon graduation (students), as determined by the School of Visual Arts in reviewing the request. The assigned expiration is at the sole determination of SVA. **A medical exemption may be granted upon receipt of a completed form (below) not more than 6 months old, signed and certified by a licensed healthcare provider, not related to the submitter, and whose specialty is appropriate to the associated condition.**

Individuals with an approved exemption may be required to comply with additional testing and other preventive requirements. In the event of an outbreak on or near campus, individuals holding exemptions may be excluded from all campus facilities and activities, for their protection, until the outbreak is declared to be over. Student Health and Counseling Services will carefully review all requests, though approval is not guaranteed. Please allow at least 15 business days for your request to be processed and forwarded for review. After your request has been reviewed and processed, you will be notified, in writing, if an exemption has been granted or denied. If the approved exemption contains an expiration, you will be expected to complete the requirement at that time.

Should the condition continue, or a new immunization contraindication occur, a new request with updated documentation is required. The decisions are final and not subject to appeals.

Individuals who requests have been denied are permitted to reapply if new documentation and information should become available.

In order to submit a request, please:

- **Read the CDC COVID-19 Vaccine Information;**
- **Complete the following page of this form;**
- **Have your provider complete the provider section of this form;**
- **Attach all supplemental materials**
- **Send the completed form to [student-covid-alert@sva.edu](mailto:student-covid-alert@sva.edu)**

*Note: incomplete submissions will delay the approval process. Be sure all forms and documentation are submitted at one time.*

**Initial next to each of the statements below:**

|  |  |
|--|--|
|  | I request exemption from the COVID-19 immunization requirements due to my current medical condition. I understand and assume the risks of non-immunization. I accept full responsibility for my health, thus removing liability from the School of Visual Arts to the required immunization.   |
|  | I understand that as I am not vaccinated, in order to protect my own health and the health of the community, I will comply with assigned COVID-19 testing requirements and other preventive guidance.  |
|  | I understand that in the event of an outbreak or threatened outbreak, I may be temporarily excluded or reassigned from SVA facilities and approved activities (including but not limited to SVA-owned housing). I agree to comply with these restrictions and accept responsibility for communicating with supervisors, human resources, faculty, and advisors as appropriate to my college affiliation. |
|  | Should I contract COVID-19, I will <u>immediately</u> report it to SVA mailto:student-covid-alert@sva.edu and comply with all isolation and quarantine procedures specified by the college and remove myself from the SVA community if so advised.   |
|  | I acknowledge that I have read the <a href="#">CDC COVID-19 Vaccine Information</a> .  |
|  | I understand that this exemption will expire when the medical condition(s) contraindicating immunization changes in a manner which permits immunization, as determined by the University in reviewing the request.   |
|  | I understand and agree to comply with and abide by all School of Visual Arts policies and procedures.  |
|  | I understand that this exception is only valid for the approved period and I may need to submit a new request for any subsequent changes, new medical contraindications, or on expiration of an approved exemption.  |
|  | I certify that the information I have provided in connection with this request is accurate and complete. I understand this exception may be revoked and I may be subject to SVA's disciplinary action if any of the information I provided in support of this exemption is false.  |
|  | I understand that the religious/medical exemption policy does not apply to the SVA residence halls. I understand that students who might be approved for an exemption are not permitted to reside in the SVA residence halls.  |

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

ID#: \_\_\_\_\_ SVA Email: \_\_\_\_\_

Phone number: \_\_\_\_\_

**Your completed form should be emailed to [student-covid-alert@sva.edu](mailto:student-covid-alert@sva.edu)**



**Attention Health Care Provider:**

School of Visual Arts policy requires that all students, faculty, and staff receive a COVID-19 vaccination.

\_\_\_\_\_ (insert patient's name) is requesting a medical exemption from this vaccination requirement. A medical exemption may be allowed for certain recognized contraindications.

**Please certify below the medical reason that your patient should not be immunized for COVID-19 by completing this form and attaching available supporting documentation.** Information provided on this form will be reviewed by a confidential committee in consideration of the exemption request.

**Option 1 - Allergy**

A documented history of a severe allergic reaction to any component of a COVID-19 vaccine or to a substance that is cross-reactive with a component. Please indicate which of the following vaccines are contraindicated and name the components, by vaccine NOTE: since egg free vaccine is available, history of egg allergy will not be accepted as a routine medical exemption.

- Moderna - List the component(s): \_\_\_\_\_
- Pfizer - List the component(s): \_\_\_\_\_
- Janssen/Johnson&Johnson - List the component(s): \_\_\_\_\_

A documented history of a severe allergic reaction after a previous dose of the COVID-19 vaccine

Please indicate to which vaccine the patient had a reaction and the date of the vaccine & reaction

- Moderna - Date of Vaccine & Reaction: \_\_\_\_\_
- Pfizer - Date of Vaccine & Reaction: \_\_\_\_\_
- Janssen/Johnson&Johnson - Date of Vaccine & Reaction: \_\_\_\_\_

**Option 2 – Physical Condition/Medical Circumstance**

The physical condition of the patient or medical circumstances relating to the individual are such that immunization is not considered safe. Please state, with sufficient detail for independent medical review, the specific nature and probable duration of the medical condition or circumstances that contraindicate immunization with the COVID-19 vaccine.

Explanation:

**Option 3 - Other**

Other. Please provide this information in a separate narrative that describes, in detail, the medical condition or disability in detail that you opine would exempt this individual from vaccination:

Explanation:

**Certification**

I certify that \_\_\_\_\_ (patient name) has the above contraindication and support the request for a medical exemption from the COVID-19 vaccine requirement at School of Visual Arts.

**Provider Information**

Medical Provider Name: \_\_\_\_\_

Medical Provider Specialty: \_\_\_\_\_

Signature: \_\_\_\_\_

Provider License Number: \_\_\_\_\_

Date: \_\_\_\_\_ Name of Provider Company: \_\_\_\_\_

Address: \_\_\_\_\_ Email: \_\_\_\_\_

Phone number: \_\_\_\_\_

**Patient Information**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

ID#: \_\_\_\_\_ SVA Email: \_\_\_\_\_

Phone number: \_\_\_\_\_