ROCKLAND COMMUNITY COLLEGE

Request for Medical Exemption

Records & Registration

Student's First Name _____ MI ___Last Name _____

SS# or College ID# _____ DOB _____

Student's Program of Study _____ Concentration/Track _____

To request a medical exemption from the SUNY COVID-19 Vaccination requirement, please complete this form and submit it to **healthrec@sunyrockland.edu**. Notification of the College's decision will be provided via your myRCC email account.

Part I. Student Acknowledgements

Please check each box to acknowledge:

☐ While my request is pending, I understand that I must comply with Rockland Community College's COVID-19 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 on any of the RCC campuses.

☐ 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 Rockland Community College's COVID-19 health and safety protocols (e.g., mask/face coverings, social distancing, regular surveillance testing) as a condition of my on-going physical presence on any of the RCC campuses. 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 and RCC 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.

Student Signature*: _____ Date: _____

**For students under 18 years old as of the first day of classes, a parent or Legal Guardian must sign.*

Please note that Rockland Community College reserves the right to request additional documentation to support a request for a medical exemption.

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Part II. Medical Exemption Request (to be completed by medical provider)

A licensed medical provider (Physician, Physician's Assistant, or Nurse Practitioner) and the student should review the CDC guidance regarding contraindications for COVID-19 vaccines. The licensed medical provider must complete Section A to identify Contraindication and/or Section B to identify a Disability and complete their provider information in Section C.

Section A. Licensed 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):

_____

_____

_____

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 student.

Licensed Medial Provider 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

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Section B. Licensed 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):

_____

_____

_____

_____

_____

The patient's disability is: ☐ Permanent
☐ Temporary

If temporary, the expected end date of the disability is: _____

Section C. Licensed Medical Provider Information and Signature

Provider Name: _____

Provider National Provider Identifier (NPI): _____

Provider Specialty: _____

Provider Employer/Affiliation: _____

Provider Phone: _____

Provider Signature: _____ Date _____