**Goldfarb Nursing School Request for Medical Exemption from Vaccination**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­\_\_\_\_\_\_\_\_ Date of Request: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Academic Program: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Academic Term: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**New Students Only:** Start Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Returning from LOA:** Return Date: \_\_\_\_\_\_\_\_\_\_

I hereby authorize the Occupational Health Department to release information to the Vice Dean for Student Affairs and Diversity to confirm my receipt of the Influenza/COVID-19/\_\_\_\_\_\_\_\_\_\_\_ vaccination or that I am exempt from the Influenza/COVID-19/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ vaccination requirement in accordance with policies established by BJC HealthCare. The specific reason for exemption will not be disclosed to the Vice Dean for Student Affairs and Diversity.

I understand that this Authorization will enable the release of the information concerning my Influenza/COVID-19/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ vaccination to the Vice Dean for Student Affairs and Diversity consistent with BJC HealthCare Policy 3.18, Employee Immunization and Screening Policy. Additionally, I understand that once this information has been released pursuant to this Authorization, it may no longer be protected by Federal and/or State law/regulations. I may request a copy of my signed Authorization if desired.

I understand that I may revoke this Authorization at any time, except to the extent that prior action has been taken in reliance on this Authorization. This Authorization will expire when I am no longer a student enrolled at Goldfarb School of Nursing if I do not cancel it in writing prior to the expiration date. I understand that if I want to cancel/revoke this Authorization, I must mail, fax, or bring a letter in person to the Occupational Health Department where I received the Influenza/COVID-19/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ vaccination, stating that I want to cancel this Authorization.

If I am granted an exemption, I will be required to abide by additional infection control measures, which may include

* students may not be assigned to bone marrow transplant units or to patients who are severely immunocompromised;
* wearing a surgical or isolation mask in all areas while at work;
* physical distancing;
* weekly surveillance testing; and/or
* any other mitigation measures to guard against the spread of Influenza/COVID-19/\_\_\_\_\_\_\_\_\_\_\_ adopted by the facility where I attend clinicals.

Student Signature+: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**+(Ink Signature Required)**

Next steps:

* Upon completion of this form, please email the form as an attachment to BJC Occupational Health for processing at [BJCOH@bjc.org](mailto:BJCOH@bjc.org).
* All completed forms will be reviewed on a case-by-case basis by the medical director of Occupational Health or Infection Prevention.
* Clarification from the requesting student and/or their licensed practitioner may be requested in writing or by phone.
* BJC will make every attempt to notify you of the determination made on your request by email within 5 business days but may be delayed if unforeseen circumstances arise.

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

Dear Licensed Practitioner:

As a patient safety initiative, BJC HealthCare is requiring SARS-CoV-2 (COVID-19) vaccination(s) for all BJC employees, students, contracted clinical personnel and volunteers, similar to other required vaccinations (such as MMR and influenza). Your patient is requesting to be exempt from this vaccination. Medical exemption from Covid-19 vaccination is allowed ONLY for recognized contraindications. Please complete the information below to request medical exemption for your patient. Should you have any questions, please call Occupational Health at (314) 362-5056.

Thank you, BJC HealthCare Occupational Health

Licensed Practitioner’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Licensed Practitioner’s Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**COVID-19 VACCINE MANDATE EXEMPTION REQUEST**

My patient should not be vaccinated against COVID-19 for the following reason:

 Recognized contraindication to COVID-19 vaccination (please mark which one):

 History of previous severe allergic reaction (e.g., anaphylaxis) to the COVID-19 vaccine or component of the vaccine

 Defined as developing hives, swelling of the lips, throat or tongue, difficulty breathing.

 Does not include sore arm, local reaction, or subsequent upper respiratory tract infection.

 Specify which vaccine received:  Pfizer  Moderna  Johnson&Johnson/Janssen

 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Documented allergy to polyethylene glycol (PEG)

 Documented allergy to polysorbate

 Documented anaphylaxis or severe immediate allergic reaction to a dose of a MRNA COVID-19 vaccine (e.g., Pfizer-BioNtech or Moderna)

 Documented anaphylaxis or severe immediate allergic reaction to a dose of adenovirus vector vaccine (e.g., Johnson & Johnson or AstraZeneca)

 Other (please describe in space below) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

My patient’s vaccination should be temporarily delayed because of the following reason:

 Receipt of COVID-19 monoclonal antibody treatment Date of infusion: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Recent COVID-19 acute infection within 90 days Date of first positive test: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Diagnosis of Multi-system Inflammatory Syndrome-Adults (MIS-A) (accompanying medical documentation required)

Based on the clinical contraindications above, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[INSERT NAME] should be exempt or temporarily delayed [CIRCLE ONE] from receiving the following COVID-19 vaccines (Check all that apply):

 Pfizer-BioNTech  Moderna  Johnson & Johnson/Janssen

I attest that I am a Licensed Practitioner within the State of \_\_\_\_\_\_\_\_\_\_\_\_, and the State’s Scope of Practice Laws allow me to complete this medical exemption form. I hereby recommend that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [INSERT NAME] be exempt [or temporarily delayed] from the COVID-19 vaccination requirements.

Licensed Practitioner’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Credentials: \_\_\_\_\_\_\_\_\_\_\_

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

**(Signature stamps will not be accepted)**

**ALL OTHER VACCINES EXEMPTION REQUEST**

My patient should not be vaccinated against \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ for the following reason:

 Pregnancy

 Recognized contraindication to \_\_\_\_\_\_\_\_\_ vaccination (please mark which one):

 History of previous severe allergic reaction to the \_\_\_\_\_\_\_\_\_\_ vaccine or component of the vaccine. Severe allergic reaction is defined as developing hives, swelling of the lips or tongue, difficulty breathing. It does not include sore arm, local reaction, or subsequent upper respiratory tract infection.

 History of Guillain-Barre syndrome within six weeks of receiving a previous vaccine. Individuals with this history can choose to receive the vaccine.

 Severe allergic reaction to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ vaccine, or have HIV, or on high-dose corticosteroids, or have an immunocompromising condition.

 Other (please describe in space below).

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

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

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

I hereby recommend that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [INSERT NAME] be exempt from the \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ vaccination requirements.

Licensed Practitioner’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Credentials: \_\_\_\_\_\_\_\_\_\_\_

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

**(Signature stamps will not be accepted)**

