Charles R. Drew University of Medicine and Science
A Private University with a Public Mission

Request for Medical Exemption from Covid-19 Vaccine Medical Certification Form

Attention Healthcare Provider:

Charles R. Drew University of Medicine and Science policy requires that all students 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 One: 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): _____
- 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 and Reaction:
- Pfizer – Date of Vaccine and Reaction:
- Johnson & Johnson – Date of Vaccine and Reaction:

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☐ **Option Two: 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 Three: 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:

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Certification:

I certify that _____ **(Insert patient's name)** has the above contraindication and support the request for a medical exemption from the COVID-19 vaccine requirement at Charles R. Drew University of Medicine and Science.

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: _____

CDU ID Number: _____ CDU Email Address: _____

Phone Number: _____

Once this document is completed, it must be uploaded with your COVID-19 Vaccination Exemption Request Form for your request to be completed.