

## COVID-19 VACCINE MEDICAL ACCOMMODATION FORM

<b>Athlete Name:</b>	<b>Athlete's DOB:</b>
<b>Athlete Email:</b>	<b>Athlete Phone:</b>
<b>Parent/Guardian Name:</b>	<b>Parent/Guardian Phone:</b>
<b>Parent/Guardian Email:</b>	

### COVID-19 Mandatory Vaccination Medical Exemption Request:

Exemption Length	Reason for Request
<input type="checkbox"/> Temporary. Exemption requested through: _____	<input type="checkbox"/> Having been treated for COVID-19 with monoclonal antibodies or convalescent plasma (90-day exemption) <input type="checkbox"/> Having been diagnosed with a multisystem inflammatory syndrome (90-day exemption) <input type="checkbox"/> Recent COVID-19 infection and within the isolation period or continued symptoms and advised by a medical provider to defer vaccination. (90-day exemption) <input type="checkbox"/> Other. Another medical condition where it is advised by a medical provider to defer vaccination until a future date. Please explain fully on the reverse side.
<input type="checkbox"/> Permanent.	<input type="checkbox"/> Documented history of severe allergic reaction to a component of each currently available COVID-19 vaccine. <input type="checkbox"/> Documented history of severe or immediate-type hypersensitivity allergic reaction to a COVID-19 vaccine, and separate contraindication to other available formulations. <input type="checkbox"/> Receiving immunosuppressive (weakens the immune system) treatment and advised by a medical provider to defer vaccination until a future date. <input type="checkbox"/> Other. Another medical condition where it is advised by a medical provider to forgo vaccination. Please explain fully on the reverse side.
Other. Please explain fully and attach additional sheets as necessary.	



Medical contraindications and precautions for immunizations are based on the most recent General Recommendations of the Advisory Committee on Immunization Practices (ACIP)/CDC, available at <https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html> or <https://www.cdc.gov/vaccines/covid-19/index.html>

Please check the website to ensure that you are reviewing the most recent CDC/ACIP information. Please note that the presence of a moderate to severe acute illness with or without fever is a precaution to the administration of all vaccines. However, as acute illnesses are short-lived, medical exemptions should not be submitted for this indication.

**Attestation**

I am a physician (M.D. or D.O) licensed to practice medicine in a jurisdiction of the United States or an advanced practice nurse licensed in a jurisdiction of the United States.

By signing below, I affirm that I have reviewed the current CDC/ACIP Contraindications and Precautions and affirm that the stated reason for an exemption request is enumerated by the CDC/ACIP and consistent with established national standards for vaccination practices. I understand that I might be required to submit supporting medical documentation.

Healthcare Provider Name (Please print): \_\_\_\_\_ Specialty: \_\_\_\_\_

NPI #: \_\_\_\_\_ License #: \_\_\_\_\_ State of Licensure: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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

**Submitted by:** \_\_\_\_\_  
Parent Name Parent Signature Date

[INTERNAL USE ONLY]

Accommodation Decision:  Approved as requested.  Approved, but different from the original request.  Denied.

Identify the accommodation provided.

If an alternative accommodation was offered, indicated whether it was:  Accepted.  Rejected.

If the accommodation is denied and no alternative accommodation was proposed, explain the basis for denying the request without alternative accommodation.

Deciding Official Name: \_\_\_\_\_ Deciding Official Signature: \_\_\_\_\_ Date: \_\_\_\_\_

