Employee/Student Health

UPSTATE MEDICAL UNIVERSITY

Employee/Student Health
Jacobsen Hall
750 East Adams Street
Syracuse, NY 13210
315-464-4260 (telephone)
315-464-5471 (fax)
www.upstate.edu/health

SUNY Upstate Medical University
COVID-19 VACCINATION REQUIREMENT
MEDICAL EXEMPTION REQUEST FORM

STUDENT INFORMATION:

LAST NAME	FIRST NAME	UPSTATE EMAIL ADDRESS	DATE OF BIRTH	STUDENT ID #:

Students who have an allergy to the available COVID-19 vaccines or a specific medical condition or circumstance that precludes receipt of the COVID-19 immunization may be eligible for a medical exemption to the COVID-19 vaccination requirement. Students should consult with a treating health care provider (a licensed physician, physician assistant, nurse practitioner, or licensed midwife) and ensure that this form is completed and returned to Employee Student Health by email ESHealth@upstate.edu or Fax 315-464-5471.

Please note that medical exemptions may expire when the medical condition(s) contraindicating COVID-19 immunization terminates or otherwise changes in a manner which permits immunization.

HEALTH CARE PROVIDER INFORMATION:

The above-referenced patient is requesting a medical exemption from SUNY Upstate's COVID-19 vaccination requirement. A medical exemption may be allowed for certain recognized contraindications.

Please certify below the medical reason(s) that the above-referenced patient should not be immunized for COVID-19 by completing this form. Information provided on this form will be reviewed and maintained on a confidential basis.

OPTION 1: ALLERGY

☐ A documented history of a severe allergic reaction to any component of the currently available COVID-19 vaccines.

Please indicate the component which caused the patient a severe allergic reaction, the date given and the reaction.

_____

_____

_____

☐ A documented history of a severe allergic reaction after a previous dose of COVID-19 vaccine. Please indicate which vaccine the patient had a severe allergic reaction to, the date of the vaccine and the reaction.

_____

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_____

OPTION 2: PHYSICAL CONDITION/MEDICAL CIRCUMSTANCE

☐ The patient's medical condition or circumstance is such that COVID-19 immunization is not considered safe at this time.

Please state, with sufficient detail for independent medical review, the specific nature and probable duration of the medical condition or circumstance that contraindicates COVID-19 immunization.

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_____

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_____

OPTION 3: OTHER

☐ Other

In your medical judgment, please describe the other condition or circumstance that you believe exempts this patient from COVID-19 vaccination at this time.

_____

_____

_____

_____

_____

_____

HEALTH CARE PROVIDER CERTIFICATION:

I certify that the above-referenced patient has the above contraindication and support the request for a medical exemption from the COVID-19 vaccine requirement.

Physician Signature: _____ Date: _____
(Note: Signature Stamp Not Acceptable)

Printed Name: _____

Physician Medical License No.: _____

STUDENT CERTIFICATION:

Please check each box to acknowledge:

☐ While my request is pending, I understand that I must comply with SUNY Upstate's COVID-19 related health and safety protocols applicable to unvaccinated or partially vaccinated individuals.

☐ 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 for exemption is granted, I understand that I will be required to comply with SUNY Upstate's COVID-19 related health and safety protocols (*e.g.*, masking and/or enhanced PPE; social distancing; undergoing periodic testing for COVID-19) if accessing a SUNY Upstate facility is a condition of my on-going physical presence. I am aware that should a COVID-19 outbreak occurs at the campus, that I may be excluded from all in-person classes and activities and that if I am enrolled in a 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 policies in place at that time.

Verification and Accuracy:

I certify that the above information is complete and accurate to the best of my knowledge, and I understand that any intentional misrepresentation contained in this request may result in disciplinary action up to and including dismissal from the program. I also understand that my request for an exemption may not be granted if it is not reasonable or if it creates an undue hardship for SUNY Upstate Medical University.

Signature: _____ Date: _____

Requests for exemptions, and any documents provided in connection, will be kept confidential and shared only with those SUNY Upstate Medical University employees who have a need to know.