EASTERN MICHIGAN UNIVERSITY

COVID-19 VACCINATION – MEDICAL ACCOMMODATION REQUEST FORM

Name:_____ Date:_____

EID:_____ Date of Birth:_____

Contact Phone Number:_____

Individuals who have a medical condition that would prevent them from being able to receive vaccines must present documentation from their physician/practitioner.

Have you ever had a life-threatening allergic reaction after a dose of COVID-19 vaccine? Yes ☐ No ☐

If Yes, please provide the manufacturer of the vaccine, approximate date of COVID-19 vaccine administration, and a brief description of your allergic reaction:

_____

Have you ever had a life-threatening allergic reaction to any of the vaccine ingredients? Yes ☐ No ☐

If yes, name(s) of the ingredients:_____

Signature: _____

HEALTH CARE PROVIDER TO COMPLETE

A Michigan-licensed physician/practitioner to complete and sign request for exemption.

Physician/Practitioner Statement: The above-named individual from EMU is under my care. I have reviewed the Covid-19 vaccine recommendations from the Centers for Disease Control (CDC) and request the following medical accommodation based on a true medical contraindication as outlined by the CDC:

- ☐ Permanent Exemption related to:
  - ☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose of Covid-19 vaccine
  - ☐ History of anaphylactic reaction to Covid-19 vaccine ingredient: _____
- ☐ Temporary Exemption related to: ☐ Pregnancy ☐ Acute COVID-19 in the last 90 days
- ☐ Other: _____

This individual will be able to receive vaccine on or after (date):_____

Please Indicate Vaccine manufacturer(s) you are exempting student from:_____

Provider Name (print):_____ MI Medical License #:_____

Address:_____ Phone:_____

Signature:_____ Date:_____

As options for the Covid vaccine expand, there may be vaccines available that will be medically safe for the individual. The Campus Health Committee reserves the right to request recertification of this exemption.