

# University at Buffalo Student Health Services

## COVID-19 Primary Vaccine

### Medical Exemption Request Form

**Section I: Student Information** (to be completed by student or legal guardian if student is under 18 years old)

Last Name	First Name	Student Email	Date of Birth	UB Person #

☐ I understand that if I have not completed the COVID-19 primary vaccine, I will need to abide by all COVID-19 related health and safety restrictions if accessing a SUNY facility, including, but not limited to, use of face masks, physical distancing, and participation in surveillance testing. I am aware that students with approved exemptions can be excluded from SUNY facilities if the campus is experiencing a high level of positive cases.

\_\_\_\_\_  
Signature of student or legal guardian if student is under 18 years old

\_\_\_\_\_  
Date

**Section II: Medical Exemption Request** (to be completed by a licensed physician, physician assistant, or advanced practice RN)

*All information is reviewed by Student Health Services' medical team which includes physicians board-certified in internal medicine, family practice, and infectious disease. Upon review, supplemental documentation may be requested.*

The licensed medical provider and student should review the [CDC guidance](#) regarding contraindications for COVID-19 vaccines.

**Medical Provider Certification of Contraindication/Precaution:** I certify that my patient (named above) cannot be vaccinated against COVID-19 because of the following contraindication or precaution:

☐ History of a severe allergic reaction (anaphylaxis) after a previous dose or to a component of the COVID-19 vaccine. **In the space below, provide the name of the vaccine or vaccine component and describe the reaction.**

☐ History of an immediate (within 4 hours) allergic reaction to any vaccine or to any injectable therapy, excluding allergy shots. **In the space below, provide the name of the vaccine/injection and describe the reaction.**

☐ History of Multisystem Inflammatory Syndrome in Children (MIS-C) or Adults (MIS-A). **In the space below, provide the date of diagnosis and clinical course.**

☐ Myocarditis or pericarditis after receipt of a dose of an mRNA COVID-19 vaccine. **In the space below, document vaccine name and date of receipt, date of onset of myocarditis or pericarditis, treatment, and clinical course.**

☐ Moderate or severe acute illness. **In the space below, provide diagnosis, clinical course, and expected date of recovery. The temporary exemption will expire once illness has improved.**

☐ Current use of immunosuppressive therapy. To optimize student's medical condition and response to vaccine, COVID-19 vaccines should be administered at least 2 weeks before initiation or resumption of immunosuppressive therapies. **In the space below, provide the name of the immunosuppressive therapy and anticipated date of its completion. The temporary exemption will expire 2 weeks after completion of therapy unless further information is provided.**

☐ TTS (thrombosis with thrombocytopenia syndrome) following receipt of a Janssen COVID-19 vaccine or any other adenovirus vector-based COVID-19 vaccine. These people should receive a dose of an mRNA COVID-19 vaccine after their clinical condition has stabilized. **In the space below, provide date and name of vaccine, clinical course of TTS, and hematologist's recommendation regarding timing of the booster vaccination.**

Name of patient: \_\_\_\_\_

Medical provider-supplied details, as requested in selected option above:

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Healthcare Provider Information	
Name (print):	Address/Clinic Stamp/Phone number:
Signature:	Date:

Once completed, students should upload the signed form to the Upload section of Student Health Services' Portal at <https://patientportal.buffalo.edu>

Uploaded exemption request forms will be reviewed. Decisions will be released through the secure messaging function of the Student Health Services' portal.