INDIANA UNIVERSITY

COVID-19 Vaccine Mandate Medical Exemption Form

This form should be completed by a medical provider. Please answer the following questions to help us understand the reasons for requesting a Medical Exemption to the COVID-19 vaccines.

1. What is your patient's first and last name? _____

2. Does the patient have a documented severe life-threatening allergic reaction (anaphylaxis requiring epinephrine) or immediate systemic allergic reaction (within 4 hours of receipt) to all of the FDA authorized COVID-19 vaccines or a component of each of them? https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html#Appendix-C

☐ Yes ☐ No

If yes, please indicate the vaccine type or the component to which the allergy has been documented:

If yes, please indicate the type of allergy experienced:

3. Does the patient have a reason to defer vaccination due to any of the following medical reasons?

a. Patient is currently pregnant, and does not want to receive any of the COVID-19 vaccines until their pregnancy is complete (note that this is not a contraindication to vaccination but we are allowing individual discretion, COVID-19 vaccination of pregnant women is recommended by the CDC https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html#pregnant).

☐ Yes ☐ No

If yes, estimated due date: _____

INDIANA UNIVERSITY

COVID-19 Vaccine Mandate Medical Exemption Form (continued)

b. Patient is currently breastfeeding, and does not want to receive any of the COVID-19 vaccines until they are no longer breastfeeding (note that this is not a contraindication to vaccination but we are allowing individual discretion, COVID-19 vaccination of breastfeeding women is recommended by the CDC https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html#pregnant).

☐ Yes ☐ No

If yes, estimated breastfeeding end date: _____

If yes, I have discussed with my patient that they have a duty to update this exemption request when the patient is no longer breastfeeding.

☐ Yes ☐ No

c. Patient has undergone hematopoietic or solid organ transplant within the past 3–6 months.

☐ Yes ☐ No

If yes, date of transplant: _____

If yes, end date of requested exemption (must be within 3–6 months of transplant): _____

d. Patient has been treated with rituximab within the past 3–6 months.

☐ Yes ☐ No

If yes, date of receipt of this medication: _____

If yes, end date of requested exemption (must be within 3–6 months of last dose of rituximab):

_____

INDIANA UNIVERSITY

COVID-19 Vaccine Mandate Medical Exemption Form (continued)

e. Patient has received COVID-specific monoclonal antibodies in the past 90 days (with provider documentation).

☐ Yes ☐ No

If yes, name of the medication: _____

If yes, date of receipt of this medication: _____

If yes, end date of requested exemption (must be within 90 days of receipt): _____

4. Provider name: _____

5. Provider NPI: _____

6. Provider specialty: _____

7. Provider employer/affiliation: _____

Provider signature: _____ Date of signature: _____