COMMUNITY COLLEGE OF RHODE ISLAND

COVID-19 Vaccination Medical Exemption Form for Students

Name:_____ **Birth date**___/___/_____ **CCRI ID:** _____

(Please print clearly) **Month Day Year**

I have been offered a COVID-19 vaccine, provided with information about its safety and efficacy, and am aware of CCRI's COVID-19 vaccination policy for students.

I am being informed of the following:

Initial_____COVID-19 is a serious disease that has killed more than 500,000 people in the United States.

Initial_____COVID-19 vaccination is recommended for me and for all other members of the CCRI community to protect me and other members of the campus community from COVID-19 and its complications, including serious illness and death.

Initial_____If I contract COVID-19, I may spread the virus for 10-14 days without exhibiting symptoms, which may place family, friends and other community members at risk.

Initial_____I understand that I cannot get COVID-19 from the COVID-19 vaccines.

If I chose to request a medical exemption, I acknowledge the following:

Initial_____I understand that CCRI must approve all exemption requests and may require additional specialty evaluation as part of that process.

Initial_____I understand that individuals who are not vaccinated against COVID-19 because they received a medical exemption **may be required to follow additional health and safety precautions not applicable to fully vaccinated individuals** including but not limited to:

- Regular asymptomatic testing
- Masking and social distancing
- Daily health checks
- Isolation if I test positive for COVID-19 and quarantine if I am identified as a close contact of a person who tests positive
- Restrictions on travel, and required testing and/or quarantine following travel
- Limitations of access to certain events, spaces, roles and activities

Further, I understand that I can change my mind at any time and receive a COVID-19 vaccination.

Despite these facts, I am requesting an exemption from vaccination because I have one of the medical contraindications to COVID-19 vaccine listed below.

- ❑ I have a documented severe allergy to each of the available vaccines.
- ❑ I am receiving immunosuppressive treatment and have been advised by my medical provider to defer vaccination until a future date.
- ❑ I have another medical condition and have been advised by my medical provider to defer vaccination until a future date.

➢ **Please attach documentation of the reason for your exemption request from your medical provider using the attached form. Additional information may be requested if needed to make a determination.**

I have read and understand the information on this form.

Signature:_____ Date:_____

Signature:_____ Date:_____

(Parent's signature required if under 18)

Upload your SIGNED document and Medical Provider Form to your MyCCRI account beginning July 19, 2021

COMMUNITY COLLEGE OF RHODE ISLAND

Patient Name_____**DOB:**_____**CCRI ID:** _____

❒CCRI Student.

Medical Provider Documentation for Covid Vaccination Exemption Request

You have been asked to provide documentation supporting a request for medical exemption from CCRI's COVID-19 vaccination requirement for all student. Please include your medical opinion and all pertinent data supporting your opinion, as indicated below. Attach additional pages as needed.

Medical Provider Name and Title: _____

Specialty:_____**Institution/Practice Name:** _____

Contact phone number:_____**Email address:** _____

Medical condition or medication warranting exemption. Please be specific. In the event of prior vaccine reactions, please specify the vaccine and the nature of the reaction. Allergy to PEG must be documented as severe or immediate-type reaction**.**

Supporting data (please include any pertinent labs or studies, specialist progress notes):

Exemption is temporary and vaccination can be initiated at a future date: ❒ Yes ❒ No

Anticipated duration of temporary exemption: _____

Medical Provider Name (printed): _____

Signature:_____**Date:** _____