REQUEST FOR **MEDICAL EXEMPTION** FROM COVID-19 VACCINE

When requested, the College will provide an exemption for a known medical condition which exempts the student from receiving a COVID-19 vaccine. To request a medical exemption, students complete Part 1 of this form and the student’s medical provider completes Part 2. **Return Part 1 and Part 2 of this form together** to ACHA by email at healthagency@allegheny.edu or postal mail at ACHA, 520 N. Main Street, Meadville, PA 16335. This information will be kept confidential and will be used by the ACHA to determine eligibility for exemption.

Medical exemptions for the COVID-19 vaccine will be considered if the student provides a written certification by a licensed, treating physician (MD or DO), nurse practitioner (NP), or physician assistant (PA) attesting to the medical circumstances relating to the person such that vaccination is not considered safe.

**PART 1 — TO BE COMPLETED BY THE STUDENT**

Full Name: ________________________________     Student ID #: ____________

**Verification of Accuracy:**

I verify that the information I am submitting in support of my request for exemption is complete and accurate to the best of my knowledge, and I understand that not completing necessary steps of medical exemption may result in disciplinary action. I also understand that my request for an accommodation may not be granted if it is not medically reasonable.

Student Initials ______

**Medical Release:**

I hereby authorize my medical provider to release my medical information to Allegheny College for the purpose of requesting a vaccine exemption. I understand that I may revoke this authorization in writing at any time, except to the extent that Allegheny College has taken action in reliance of this authorization, and if I revoke this authorization, such revocation will not have any effect on disclosures made prior to such revocation. I have had the opportunity to read and consider the contents of this authorization. I confirm that the contents are consistent with my direction. A photocopy of this form shall have the same legal validity as the original.

Student Signature: ____________________________________________

Date: ______________________
PART 2 – TO BE COMPLETED BY THE STUDENT’S MEDICAL PROVIDER

Institution’s Name: Allegheny College (the “College”)

Student’s Name: __________________________________________

DOB: _______________________________ Student ID # _______________________________

ATTN: Medical Provider

The College requires all students to receive the COVID-19 vaccine prior to arrival on the College’s campus for the fall 2021 academic semester. A medical exemption may be allowed for certain recognized contraindications. The above-named person should not be immunized for COVID-19 for the following reasons:

☐ History of previous allergic reaction to a component of the vaccine. Please list vaccine name, reaction type, and date of reaction:

___________________________________________________________________________________________________________________________________________

☐ The physical condition of the person or medical circumstances relating to the person are such that immunization is not considered safe. Please indicate the specific nature and probable duration of the medical condition or circumstances that contraindicate immunization:

___________________________________________________________________________________________________________________________________________

☐ Other – Please provide a narrative that describes the exemption in detail:

___________________________________________________________________________________________________________________________________________

I, the undersigned, do hereby certify that the above-named student has the above contraindication and qualifies for a medical exemption from the COVID-19 vaccination.

Medical Provider Signature: __________________________________________

License Number: ___________________________ Date: ___________________________

Print Name: __________________________________________

Office Address: __________________________________________

Email: __________________________________________ Phone: ___________________________

Return Part 1 and Part 2 of this form together to ACHA by email at healthagency@allegheny.edu or postal mail at ACHA, 520 N. Main Street, Meadville, PA 16335. For questions or additional information, please contact us at healthagency@allegheny.edu.