DUTCHESS
COMMUNITY COLLEGE

Medical Exemption Request for SUNY COVID 19 Vaccination Requirements-Enrollment in credit courses

Please read and follow all instructions to avoid delay or completion of the request.

Submission Deadline: One week prior to the start of the semester.

Include in Email Subject Line: Full Name, Medical Exemption.

Allow up to five business days for review and response to your request.

To request a medical exemption from the SUNY COVID-19 vaccination mandate, **you must complete this form, which includes three parts, use your own SUNY Dutchess email and submit it to vaxexemption@sunydutchess.edu.** If you do not use the vaxexemption@sunydutchess email address or do not file by the deadline, *your request will not be processed*. A decision regarding your request will be sent to your DCC email and will only be communicated to the student making the request. **Medical Exemption requests are reviewed by the DCC Health Office**.

Per SUNY Policy, all students who plan to attend in-person classes and/or utilize in-person services at a SUNY facility or campus must provide evidence of receiving a full vaccination series (i.e., both doses of a two-dose series, and booster vaccination when eligible) of any COVID-19 vaccination or have provided proof that they have completed the full vaccination series.

Part I. Student Information and Certification:

LAST NAME	FIRST NAME	STUDENT EMAIL ADDRESS	DATE OF BIRTH	STUDENT ID #

Please check each box to acknowledge:

☐ I certify that I have confirmed with my academic program that not receiving the COVID-19 vaccination will not prevent the completion of my programmatic or curricular requirements.

Name of Program_____

☐ If my medical request is granted, I understand that I will be required to comply with the campus's COVID-19 related health and safety protocols (e.g., mask/face coverings, social distancing, weekly surveillance testing, What Students Need to Know) if accessing a SUNY facility or campus as a condition of my on-going physical presence. I am aware that, should a COVID-19 outbreak occur at the campus or I test positive or I am indicated as a close contact of a confirmed positive, I may be excluded from any presence in a SUNY facility, all in-person classes and activities that require a physical presence on campus, and I may not be able to complete my academic coursework remotely. I acknowledge that my right to any refund in the event of a COVID-19 outbreak will be subject to all existing SUNY policies.

☐ If my medical request is granted and I fail to continue to comply with the campus' COVID-19 related health and safety protocols, I can face Student Code of Conduct charges. Outcomes for such violations can range from verbal warnings to termination of exemptions to removal from face-to-face coursework and on campus presence, and administrative withdrawal.

☐ I certify that my statements above, and my statements in all supporting documentation, are true and accurate, and that the receipt of the COVID-19 vaccination may be detrimental to my health. I understand that I am fully responsible for my health; I fully assume any and all risks associated with not receiving immunizations/vaccinations; and Dutchess Community College cannot be responsible for your actions in this matter. False statements on these documents could result in Student Code of Conduct charges. Outcomes for such violations can range from termination of exemptions to removal from face-to-face coursework and on-campus presence, and administrative withdrawal.

☐ If my previous request was granted, I understand that if I did not comply with the campus's COVID-19 related health and safety protocols (e.g., mask/face coverings, social distancing, weekly surveillance testing) if accessing a SUNY facility is a condition of my ongoing physical presence, I may not be eligible for another approved exemption.

☐ If my request is granted, I understand that the exemption applies only for the upcoming semester and only to Dutchess Community College and to no other organizations or programs. The exemption will not apply in any internship/externship/clinical rotations or placements that may require specific immunizations/vaccinations. Furthermore, I understand that I may need to contact the department/program chair in reference to specific accommodations for my program regarding a medical exemption.

☐ I have read and understand all the information above and the necessary planning to enroll in credit courses before the start of the semester, and understand holiday and/or emergency weather closings will impact the timeline.

Signature*:_____Date: _____

*Student (Parent or Legal Guardian must sign if the student is under 18 years old as of the first day of classes).
Parent/Legal Guardian Full Name

[Please print legibly]

Parent/Guardian Email: _____

Phone: _____

Please note that the campus reserves the right to request additional documentation to support a request for a medical exemption.

Part II. Medical Exemption Request (to be completed by medical provider)

A licensed medical provider (physician, physician's assistant, or nurse practitioner) and student should review the CDC guidance regarding contraindications for COVID-19 vaccines. The provider must complete Section(s) A and/or B and provide their provider information in Section C.

Section A. Medical Provider Certification of Contraindication:
I certify that my patient (named above) cannot be vaccinated against COVID-19 because of the following contraindication:
Please select which of the medically indicated COVID-19 vaccine contraindications defined by the CDC apply:

☐ Severe allergic reaction (anaphylaxis) after a previous dose or to a component of the COVID-19 vaccine, including Polyethylene Glycol (PEG). (***Describe reaction/response below and contraindication to alternative vaccines***.)

☐ Immediate allergic reaction to previous dose or known (diagnosed) allergy to a component of the vaccine. (***Describe reaction/response below and contraindication to alternative vaccines***).

Additional details on the selected option(s) above (to be completed by the medical provider):

_____

_____

_____

Please note that **NONE of the following are considered contraindications** to the COVID-19 vaccine.

- Local injection site reactions to previous COVID-19 vaccines (erythema, induration, pruritus, pain).
- Expected systemic vaccine side effects in previous COVID-19 vaccines (fever, chills, fatigue, headache, lymphedema, diarrhea, myalgia, arthralgia.
- Previous COVID-19 infection.
- Vasovagal reaction after receiving a dose of any vaccination.
- Being an immunocompromised individual or receiving immunosuppressive medications.
- Autoimmune conditions, including Guillain-Barre Syndrome.
- Allergic reactions to anything not contained in the COVID-19 vaccine, including injectable therapies, food, pets, oral medications, latex, etc. (Please note the COVID vaccine does not contain egg or gelatin).
- Alpha-gal Syndrome.
- Pregnancy, undergoing fertility treatment, intention to become pregnant or breastfeeding. (Please note that the American College of Obstetricians and Gynecologists, the Society for Maternal-Fetal Medicine and the Society for Reproductive Medicine all strongly recommend COVID-19 vaccination during pregnancy).
- The medical condition of a family member or other residing in the same household as the employee.

Clinician Certification: **By completing this form, you certify that different methods of vaccinating against COVID-19 have been fully considered and that the patient has the contraindication indicated above that precludes any/all available vaccinations for COVID-19. Information about approved medical exemptions for COVID-19 vaccination can be reviewed at https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html**

Section B. Medical Provider Certification of Disability That Makes COVID-19 Vaccination Inadvisable

"Disability" is defined as any impairment resulting from anatomical, physiological, genetic, or neurological conditions which prevent the exercise of a normal bodily function or is demonstrable by medically accepted clinical or laboratory diagnostic techniques and any other condition recognized as a disability under applicable law.

"Disability" may include pregnancy, childbirth, or a related medical condition where reasonable accommodation is medically advisable.

I certify that my patient (named above) has the following disability that makes COVID-19 vaccination inadvisable:

_____

Additional details on why the disability listed above makes COVID-19 vaccination inadvisable (to be completed by the medical provider):

_____

_____

_____

_____

_____

The patient's disability is: ☐ Permanent ☐ Temporary

If temporary, the expected end date is: _____

Section C. Medical Provider Information

Provider Name: _____

Provider National Provider Identifier (NPI): _____

Provider Specialty: _____

Provider Employer/Affiliation: _____

Provider Phone: _____

Provider Signature:_____Date of signature: _____