**University of Pennsylvania**
**Request for Medical Exemption from COVID-19 Vaccination**
**For Faculty, Staff and Postdoctoral Trainees**

**1. <u>To Be Completed By Faculty, Staff or Postdoctoral Trainee Seeking Exemption</u>**

Full Name: (print) _____ Penn ID: _____

Job Title: _____

School/Center: _____ Department: _____

Email Address: _____ Phone Number: _____

Brief Description of the Medical Condition Preventing You from Receiving Any of the COVID-19 Vaccines:

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I understand that if my exemption request is granted, I will be required to comply with the University's requirements for faculty, staff and postdoctoral trainees with medical or religious exemptions from the University's COVID-19 vaccination requirement, consistent with public health guidance. Those requirements may include but are not limited to daily symptom attestation through PennOpen Pass, participating in twice weekly COVID-19 screening testing through Penn Cares testing, wearing a mask in all indoor spaces and respecting physical distancing guidelines. I understand that I may be required to comply with additional obligations as required by the University, my School or Center as well as from public health officials. Based on my role and other health and safety considerations, I also understand that my work assignments and/or position could be impacted. These requirements may change or may be modified based on prevailing public health guidance in order to minimize the risk to me and to others. Finally, I understand that my exemption status may change over time as new vaccines are made available and/or my medical condition changes such that vaccination may no longer be contraindicated.

I hereby authorize the release of the following information to the University for the purpose of evaluating my request for exemption from COVID-19 vaccination. I further authorize the University to seek clarification of this documentation, if necessary, by contacting my health care provider. If my health care provider requires that a HIPAA release be signed before releasing information related to my exemption request, I agree that I will promptly execute the HIPAA release.

I hereby certify that the statements contained herein are true and correct to the best of my knowledge and belief. I understand that if I knowingly make any false statement herein, I am subject to such penalties as may be prescribed by statute or ordinance, as well as to disciplinary or other appropriate action pursuant to University policy.

Signature: _____ Date: _____

**2. To Be Completed by Health Care Provider**

Instructions for Completing this Form: Please complete this form if your patient has a medical condition that is a contraindication to COVID-19 vaccination. This form should be completed only if different methods of vaccinating against COVID-19 have been considered and you have determined that your patient's medical condition precludes your patient from receiving any of the COVID-19 vaccines.

Please refer to the Center for Disease Control's *Interim Clinical Considerations for Use of COVID-19 Vaccines Currently Authorized in the United States* for determining whether a particular medical condition is contraindicated. As further guidance, the following are NOT considered contraindications to COVID-19 vaccination:

- Local injection site reactions after (days to weeks) previous COVID-19 vaccines (erythema, induration, pruritus, pain, etc.)
- Expected systemic vaccine side effects experienced from previous COVID- 19 vaccines (fever, chills, fatigue, headache, lymphadenopathy, vomiting, diarrhea, myalgia, arthralgia)
- 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 vaccines, including injectable therapies, food, pets, venom, environmental allergens, oral medication, latex, etc.
- Breastfeeding
- Pregnancy
- Immunosuppressed person in the employee's household
- Alpha-gal Syndrome
- History of Bell's palsy
- The COVID vaccines do not contain egg or gelatin; allergies to these substances are not contraindications

The most common medically indicated contraindications include:

- Severe allergic reaction (anaphylaxis) after a previous dose of, or to a component of, the COVID-19 vaccine, including Polyethylene Glycol (PEG)
- Immediate allergic reaction to a previous dose or known (diagnosed) allergy to a component of the vaccine

Other medical circumstances preventing vaccination with any available COVID-19 vaccine will also be considered based on the specificity of the information provided.

Medical Exemption Request: Please review carefully, provide the requested information, and sign below to certify that the information you are providing is true and correct.

I certify that different methods of vaccinating against COVID-19 have been considered and that the following medical contraindication precludes any/all vaccinations for COVID-19. I also certify that the contraindication is documented in the patient's medical record.

I certify that I provide regular health care for this patient and am not a relative or personal/family friend.

I certify that this patient is under my care and should not be vaccinated against COVID-19 for the following reason(s): (please indicate as appropriate and provide details in the box below)

- ☐ Recognized contraindication to COVID-19 vaccination:
  - ☐ Documented allergy to polyethylene glycol (PEG) (precludes receipt of mRNA vaccines only)
  - ☐ Documented allergy to polysorbate (precludes receipt of Johnson & Johnson vaccine only)
  - ☐ Documented anaphylaxis or severe immediate allergic reaction to a dose of an mRNA COVID-19 vaccine (e.g. Pfizer-BioNtech or Moderna)
  - ☐ Documented anaphylaxis or severe immediate allergic reaction to a dose of an adenovirus vector vaccine (e.g. Johnson & Johnson or AstraZeneca)
- ☐ Recent COVID-19 infection with receipt of monoclonal antibody treatment within the past 90 days (temporary exemption appropriate for 90 days following infusion date)
  Date of infusion: _____
- ☐ Other medical circumstance preventing vaccination with any available COVID-19 vaccine. (Be specific & describe in detail below. Additional pages/documentation can be submitted, as necessary.)

I hereby certify that the information contained herein is true and correct to the best of my knowledge and belief. I understand that if I knowingly make any false statement herein, I am subject to such penalties as may be prescribed by statute or ordinance.

Health Care Provider Name (print): _____

Health Care Provider Signature: _____

Specialty: _____ License Number: _____ State:_____

Street Address: _____ Phone: _____

City: _____ State: _____ Zip Code: _____

*Return Completed Form to:*
*vaxexemptions@upenn.edu – or – use the secure drop box for Vaccine Exemption Requests in the Franklin Building lobby (3451 Walnut Street)*