

Student's Name: _____

AU ID: _____

Date: _____

American University Request for Medical Exemption from COVID-19 Vaccination Form

American University's Health and Safety Directive: Mandatory COVID Vaccination requires all students, faculty, and staff to be fully vaccinated and receive a COVID-19 vaccination. AU may only grant a medical exemption upon receipt of a completed exemption form. The completed form must:

- *Not* be more than six months old.
- Be signed and certified by a licensed healthcare provider (MD, DO, ND, ARNP, PA) whose specialty is appropriate to the associated condition.
 - The licensed healthcare provider cannot be related to the submitter.

Medical exemptions expire when the medical condition(s) contraindicating COVID-19 vaccination changes in a manner which permits vaccination or upon graduation (students), as solely determined by American University.


Individuals with an approved exemption will be required to comply with additional testing and other preventive requirements as required by AU's University's other Health and Safety Directives, policies, and procedures related to COVID. In the event of an outbreak on or near campus, individuals holding exemptions may be excluded from all campus facilities and activities - for their protection - until the outbreak is declared to be over. To submit a request, please:

- Read the [CDC COVID-19 Vaccine Information Page and FAQ](#)
- Complete the student section of this form
- Fill in your name, AU ID, and the date at the top of pages 1, 3, and 4, and the bottom part of page 5.
- Have your provider complete the provider sections of this form: Section 2 and 3
- Attach all supplemental materials; and
- Email all the documents together in a single email to SHC@american.edu

Please note, AU will not review incomplete or alternate submissions. Therefore, be sure all forms and documentation are submitted together in a single email.

American University Request for Medical Exemption from COVID-19 Vaccination Form: Section 1 – Student

Please initial next to each statement.

	I request exemption from the COVID-19 vaccination requirements due to my current medical condition. I understand and agree to assume the risks of non-vaccination, including but not limited to becoming sick, injured, or even death from COVID, and to hold American University (“University”) and its employees and agents harmless from the consequence or effects caused by such illness. I accept full responsibility for my health, thus removing any liability from American University for any resulting sickness, injury, or death arising from my exemption..
	If living on campus, I understand that I may have a roommate who tests positive for COVID-19 and that they may be required to isolate in the room while contagious with this infection. Unless granted a medical accommodation ahead of time, neither I, nor my roommate will be given an alternate housing option during this time period.
	I understand that as I am not vaccinated, in order to protect my own health and the health of the community, I will comply with assigned COVID-19 testing requirements and other preventive guidance as required by the University.
	I understand that in the event of an outbreak or threatened outbreak, I may be temporarily excluded or reassigned from University facilities and approved activities (including but not limited to University-owned housing) if required by the University. I agree to comply with these restrictions and accept responsibility for communicating with supervisors, human resources, faculty, and advisors as appropriate to my University affiliation.
	Should I contract COVID-19, I will immediately report it to American University (using the AUForward Portal) and comply with all isolation and quarantine procedures specified by the University and remove myself from the University community if so advised.
	I acknowledge that I have read the CDC COVID-19 Vaccine Information and FAQ : 
	I understand that this exemption will expire when the medical condition(s) contraindicating vaccination changes in a manner which permits vaccination or upon graduation, as solely determined by the University in reviewing the request.
	I understand and agree to comply with and abide by all American University policies and procedures.
	I understand that this exception is only valid for the approved period, and I may need to submit a new request for any subsequent changes, new medical contraindications, or on expiration of an approved exemption.
	I certify that the information I have provided in connection with this request is accurate and complete. I understand this exception may be revoked and I may be subject to University disciplinary action if any of the information I provided in support of this exemption is false.

Student’s Name (Printed): _____

Date: _____ AUID: _____

AUEmail: _____ Signature: _____

American University Request for Medical Exemption from COVID-19 Vaccination Form: Section 2 – Provider, Medical Review

Attention Health Care Provider: American University’s Health and Safety Directive: Mandatory COVID Vaccination requires that all students, faculty, and staff to be fully vaccinated and receive a COVID-19 vaccination. _____ (insert patient’s name) is requesting a medical exemption from this vaccination requirement. A medical exemption may be allowed for certain recognized contraindications.

Please certify below the medical reason that your patient should not be immunized for COVID-19 by completing this form and attaching available supporting documentation.

Option 1: Allergy

Known Allergy to component of the vaccine

A documented history of a severe allergic reaction to any component of a COVID-19 vaccine or to a substance that is cross-reactive with a component. Please indicate which of the following vaccines are contraindicated and name the components, by vaccine NOTE: since egg free vaccine is available, history of egg allergy will not be accepted as a routine medical exemption.

- Moderna - List the component(s): _____
- Pfizer-BioNTech - List the component(s): _____
- Janssen/Johnson&Johnson - List the component(s): _____
- Other - List the component(s): _____

Previous severe allergic reaction after previous dose of the vaccine

A documented history of a severe allergic reaction after a previous dose of the COVID-19 vaccine Please indicate to which vaccine the patient had a reaction and the date of the vaccine & reaction

- Moderna - Date of Vaccine & Reaction: _____
- Pfizer - Date of Vaccine & Reaction: _____
- Janssen/Johnson&Johnson - Date of Vaccine & Reaction: _____

Option 2: Physical Condition or Medical Circumstance

The physical condition of the patient or medical circumstances relating to the individual are such that vaccination is not considered safe. Please state, with sufficient detail for independent medical review, the specific nature and probable duration of the medical condition or circumstances that contraindicate vaccination with the COVID-19 vaccine.

Please note, the following are *not* considered contraindications to the COVID-19 vaccination:

1. Local injection site reactions after previous COVID-19 vaccination (erythema, induration, pruritus, pain)Expected systemic vaccine side effects from previous COVID-19 vaccinations (fever, chills, fatigue, headache, lymphadenopathy, vomiting, diarrhea, myalgia, arthralgia).
2. Vasovagal reaction after receiving a dose of any vaccination.
3. Being an immunocompromised individual or receiving immunosuppressive medications
4. Autoimmune conditions
5. Allergic reactions to anything *not* contained in the COVID-19 vaccines, including injectable therapies, food, pets, venom, environmental allergens, oral medication, latex etc.
6. Pregnancy or Breastfeeding
7. Immunosuppressed person in the student's household
8. Alpha-gal Syndrome
9. Allergy to egg or gelatin
10. Having a positive antibody titre
11. History of blood clots is not considered a contraindication to receiving one of the mRNA vaccines (Pfizer or Moderna).

Explanation of Physical Condition or Medical Circumstance:

Option 3: Other

Please provide this information in a separate narrative that describes, in detail, the medical condition or disability in detail that you opine would exempt this individual from vaccination:

American University Request for Medical Exemption from COVID-19 Vaccination Form: Section 2 – Provider, Certification

I certify that _____ (patient name) has the above contraindication and support the request for a medical exemption from the COVID-19 vaccine requirement at American University.

Provider Information

Provider Name: _____

Provider Specialty: _____

Provider License Number: _____

Date: _____

Phone Number: _____

Address: _____

Email Address: _____

Signature: _____

By checking this box and typing my name above, I am signing this form electronically.

Patient Information

Student's Name (Printed): _____

Student's AU ID: _____

Date: _____