

## Mandatory Vaccination (COVID and influenza) Medical Exemption Form

**Medical Exemption:** per RSFH policy, a medical exemption may be granted to accommodate disabilities and for medical criteria consistent with those published by public health authorities and/or the Centers for Disease Control (CDC).

**Directions:** This form must be fully completed by the RSFH Workforce Member and a licensed provider - physician, physician's assistant or nurse practitioner.

RSFH Workforce Member Name: \_\_\_\_\_  
RSFH Workforce Member's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
RSFH Employee Number (if applicable): \_\_\_\_\_

1. Check which this applies to:  Influenza;  COVID-19; or  Both

**MEDICAL CERTIFICATION (completed by your licensed provider)**

2. For COVID-19 - I certify that (insert patient name) \_\_\_\_\_ meets one or more of the following medical criteria that would prevent him or her from receiving the COVID vaccination: (check all that apply):

Severe allergic reaction to Polyethylene Glycol, Polysorbate, a prior COVID-19 vaccine or other vaccine leading to include anaphylaxis requiring epinephrine treatment or treatment in a hospital, hives, swelling or respiratory distress.

Currently pregnant or breastfeeding (temporary exemption). Please identify the date that the temporary exemption should resolve \_\_\_\_\_.

Another qualifying temporary or permanent medical condition for which you recommend your patient not receive the vaccination. **Please describe (and identify the date the temporary condition should resolve, if applicable):**

[continued on the next page]

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3. **For Influenza - I certify that (insert patient name) \_\_\_\_\_ meets one or more of the following medical criteria that would prevent him or her from receiving the Influenza vaccination: (check all that apply):**

Allergy to chicken eggs, egg products or to other components of the influenza vaccine.

History of Guillain-Barré Syndrome within 6 weeks of receiving an influenza vaccine.

Another qualifying temporary or permanent medical condition for which you recommend your patient not receive the vaccination. **Please describe (and identify the date the temporary condition should resolve, if applicable):**

4. **Provider Signature:**

**Check one:** I am a licensed  Physician;  Physician's Assistant; or  Nurse Practitioner

Provider's Printed Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Provider's Official's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

5. **Completed Forms:**

- a. **Employed RSFH Workforce Member:** Upload Completed Form to the RSFH Exemption Portal for consideration by the published exemption due date.
- b. **Non-Employed RSFH Workforce Member:** Follow the directions of your employer regarding submission and/or maintain this documentation as support for your RSFH Vaccination Attestation Form.