

New Team Member 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 Applicant for Hire and a licensed provider - physician, physician's assistant or nurse practitioner.

RSFH Applicant for Hire Name: _____
RSFH Applicant for Hire's Signature: _____ Date: _____

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. **RSFH Applicant for Hire:** Upload Completed Form to the RSFH Exemption Portal for consideration by the published exemption due date.