



Student Health and Counseling Center

COVID-19 Vaccination Medical Exemption Student Request Form

Student Name _____ Student ID # _____

Student Email _____ Phone Number _____

To request an exemption from a required COVID-19 vaccination due to medical reasons, students must: (i) complete this form, and (ii) submit an exemption form signed by a licensed medical provider . Students and medical providers can access forms through UAF SHCC's website: <https://uaf.edu/chc/forms>. Printable forms are available and can be uploaded to the Patient Portal by the student. Forms can also be completed online and signed digitally. Students will be notified of the exemption status within three (3) business days.

Guidance for medical exemptions for vaccination can be obtained from the contraindications, indications, and precautions described in the vaccine manufacturer's package insert and by the most recent recommendations of the Advisory Committee on Immunization Practices (ACIP) available in the Centers for Disease Control and Prevention publication, Guide to Vaccine Contraindications and Precautions. This guide can be found at the following website: <http://www.cdc.gov/vaccines/recs/vac-admin/contraindications.htm>.

By submitting this form, you agree to the following:

- I request an exemption from the COVID-19 vaccine requirement due to a medical exemption. I understand and assume the risks of being unvaccinated. I accept full responsibility for my health, thus removing liability from the University of Alaska with respect to the vaccination policy.
- I understand that in the event of an outbreak or threat of an outbreak, I may be temporarily excluded or reassigned from University of Alaska Fairbanks' facilities and approved activities. I agree to comply with these restrictions and accept responsibility for communicating with faculty and advisors as appropriate in order to allow compliance with health and safety requirements for unvaccinated individuals. I further understand that restrictions from UAF facilities, including but not limited to classes and living spaces, do not entitle me to any reduction in tuition, housing charges, or other UAF associated fees.
- I acknowledge I have read the CDC COVID-19 Vaccine Information <https://www.cdc.gov/coronavirus/2019-ncov/vaccines/index.html>.
- I understand that, if approved, this exemption is only valid for the current academic year and that I am required to resubmit a new request for any subsequent academic year.
- I understand and agree to comply with and abide by all other UAF COVID-19 policies and procedures.
- I certify that the information provided in connection with this request is accurate and complete. I understand this exemption 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.

Signature _____ Date _____



Student Health and Counseling Center

Vaccination Exemption Medical Provider Form

Student Name _____ Student ID # _____

Student Email _____ Phone Number _____

To request an exemption from a required vaccination due to a medical reason, students must submit a *Vaccination Exemption Medical Provider Form* completed and signed by a licensed medical provider. Students can upload the completed form to their Patient Portal, or their medical provider can complete an online form with a digital signature. Forms can be found using this link: <https://uaf.edu/chc/forms>.

Guidance for medical exemptions for vaccination can be obtained from the contraindications, indications, and precautions described in the vaccine manufacturer's package insert and by the most recent recommendations of the Advisory Committee on Immunization Practices (ACIP) available in the Centers for Disease Control and Prevention publication, Guide to Vaccine Contraindications and Precautions.

This guide can be found at the following website: <http://www.cdc.gov/vaccines/recs/vac-admin/contraindications.htm>.

The following section must be completed by a licensed Medical Doctor (MD), Doctor of Osteopathy (DO), Advanced Nurse Practitioner (ANP), or Physician Associate-Certified (PA-C) as applicable.

In my professional opinion, the following vaccines would be injurious to the health of the above named student. _____ (Medical provider's initials indicating their agreement with the statement)

Check appropriate antigen(s)

- | | | |
|-------------------------------------|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Tetanus | <input type="checkbox"/> Pertussis |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Mumps | <input type="checkbox"/> Rubella |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Hepatitis B |
| <input type="checkbox"/> Varicella | <input type="checkbox"/> Hib | <input type="checkbox"/> COVID-19 |

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Check appropriate antigen(s)

- | | | |
|-------------------------------------|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Tetanus | <input type="checkbox"/> Pertussis |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Mumps | <input type="checkbox"/> Rubella |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Hepatitis B |
| <input type="checkbox"/> Varicella | <input type="checkbox"/> Hib | |

Provider Name (Print) _____ License _____

Address _____ State/Location _____

Telephone _____

Signature _____ Date _____