COVID-19 Vaccination Requirement Medical Exemption Request for Students
To be Completed by the Medical Provider

A student who wishes to request an exemption to The Chicago School's COVID-19 vaccination requirement due to a **medical reason** may do so by submitting this form. This form is required and must be submitted as soon as possible and no later than October 7, 2021. Attach this completed document to the online COVID-19 Vaccination Requirement Exemption Request form located here: https://cm.maxient.com/reportingform.php?TheChicagoSchool&layout_id=8.

Section I: Completed by Student

Name: _____ Date of Birth: _____
First/Middle/Last

Primary Home Address: _____

Email Address: _____ Primary Phone: _____

Signature: _____ Date: _____

Section II: Completed by Medical Provider

Medical contraindications and precautions for immunizations are based on the most recent General Recommendations of the Advisory Committee on Immunization Practices (ACIP), available at https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html. Please check the website to ensure that you are reviewing the most recent ACIP information. Please note that the presence of a sore arm, local reaction, and moderate to severe acute illness with or without fever are possible after administration of all vaccines. However, as acute illnesses are short-lived, medical exemptions should not be submitted for this indication. Please review the ACIP Guide to confirm that any noted condition is not commonly misperceived as a contraindication or precaution in the above ACIP link.

Table 1. ACIP Contraindications and Precautions to Vaccination

Vaccine	Exemption Length	ACIP Contraindications and Precautions (CHECK ALL THAT APPLY)
□ COVID-19	□ Temporary through: _____ □ Permanent	□ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component of the COVID-19 vaccine. **Explain in full below.** □ Immediate allergic reaction of any severity to a previous dose or known (diagnosed) allergy to a component of the COVID-19 vaccine. **Explain in full below.** □ Medical condition or disability that makes COVID-19 vaccination inadvisable. **Explain in full below.** □ Other. **Explain in full below.**

Important: Do not identify the patient's diagnosis, disability, or other medical information.

Other: Please explain fully the nature and probable duration of the medical condition or circumstances that contraindicate the COVID-19 vaccine. Attach additional sheets as necessary.

_____
_____
_____
_____
_____
_____

Attestation

I am a physician (M.D. or D.O.) licensed to practice medicine in a jurisdiction of the United States or an advanced practice provider (nurse practitioner or physician's assistant) licensed in a jurisdiction of the United States.

Healthcare Provider Name (please print): _____

Signature: _____ Date: _____

State of Licensure: _____ NPI Number: _____