

# TEACHERS COLLEGE

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## COLUMBIA UNIVERSITY

### **Request for Medical Exemption from COVID-19 Vaccination and/or Booster(s) Form**

Name: \_\_\_\_\_

UNI: \_\_\_\_\_ Department: \_\_\_\_\_

Teachers College Email: \_\_\_\_\_ Phone: \_\_\_\_\_

Teachers College's policy requires that all students receive a COVID-19 vaccination/booster. **A medical exemption may be granted upon receipt of a completed form (below) not more than 6 months old, signed and certified by a licensed healthcare provider, not related to the submitter, and whose specialty is appropriate to the associated condition that includes the following:**

Medical exemptions expire when the medical condition(s) contraindicating COVID-19 vaccination/booster changes in a manner which permits vaccination/booster or upon graduation. The assigned expiration is at the sole determination of Teachers College.

Individuals with an approved exemption will be required to comply with additional testing and other preventive requirements as specified in the exemption approval and as may be updated by later notification and/or posting of requirements on the TC website. 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.

The Office of Student Wellness will review all requests, though approval is not guaranteed. After your request has been reviewed and processed, you will be notified, in writing, if an exemption has been granted. If the approved exemption contains an expiration, you will be expected to complete the requirement at that time. Should the condition continue, or a new vaccination/booster contraindication occurs, or the current exemption expires, a new request with updated documentation is required. Decisions are final and not subject to appeal. Individuals are permitted to reapply if new documentation and information should become available.

In order to submit a request, please:

- **Read the [CDC COVID-19 Vaccine Information](#);**
- **Complete the following page of this form;**
- **Have your Licensed Health Care Provider complete the provider section of this form;**
- **Submit the completed documents.**

*Note: incomplete submissions will not be reviewed. Be sure all forms and documentation are submitted at one time.*

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**Initial next to each of the statements below:**

	I request exemption from the COVID-19 vaccination/booster requirements due to my current <b>medical condition</b> . I understand and assume the risks of non-vaccination/booster. I accept full responsibility for my health, thus removing liability from Teachers College to the required vaccination/booster.
	I understand that as I am not vaccinated/boosted, in order to protect my own health and the health of the community, I will comply with additional COVID-19 testing requirements and other preventive guidance.
	I understand that in the event of an outbreak or threatened outbreak, I may be temporarily excluded from Teachers College facilities and approved activities (including but not limited to Teachers College-owned housing). I agree to comply with these restrictions and accept responsibility for communicating with faculty and advisors as appropriate to allow compliance with health and safety requirements for unvaccinated individuals. I further understand that restrictions from Teachers College facilities, including but not limited to classes and living spaces, does not entitle me to any reduction in tuition, housing charges, or other Teachers College fees.
	Should I contract COVID-19, I will <b>immediately</b> report it to Teachers College (email to <a href="mailto:covidstudentcare@tc.columbia.edu">covidstudentcare@tc.columbia.edu</a> ) and comply with all isolation and quarantine procedures specified by Teachers College and remove myself from the Teachers College community if so advised.
	I acknowledge that I have read the <a href="#">CDC COVID-19 Vaccine Information</a> .
	I understand that this exemption will expire when the medical condition(s) contraindicating vaccination/booster changes in a manner which permits vaccination/booster.
	I understand and agree to comply with and abide by all Teachers College COVID-19 policies and procedures.
	I understand that this exemption 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 authorize my licensed health care provider to provide Teachers College with medical information about my medical exemption for the COVID-19 vaccination/booster.
	I certify that the information I have provided on and in connection with this request is accurate and complete as of the date of this submission. I understand this exemption may be revoked and I may be subject to Teachers College disciplinary action if any false information has been used to request an exemption.

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

UNI: \_\_\_\_\_ Teachers College Email: \_\_\_\_\_

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Phone Number: \_\_\_\_\_

By checking this box and typing my name above, I understand and agree that I am submitting this document electronically and that it is the legal equivalent of having placed my handwritten signature on the submitted document.

Date: \_\_\_\_\_

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### Attention Health Care Provider:

Teachers College policy requires that all students receive a COVID-19 vaccination/booster.

\_\_\_\_\_ (insert patient's name) is requesting a medical exemption from this vaccination/booster requirement. A medical exemption may be allowed for certain recognized contraindications.

**Please certify below the medical reason that your patient should not be immunized/boosted for COVID-19 by completing this form and attaching available supporting documentation.** Information provided on this form will be reviewed by a confidential committee in consideration of the exemption request.

### Option 1 - Allergy

\_\_\_ A documented history of a severe allergic reaction to any component of a COVID-19 vaccine/booster or to a substance that is cross-reactive with a component. Please indicate which of the following vaccines/boosters 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 - List the component(s): \_\_\_\_\_
- Janssen/Johnson&Johnson - List the component(s): \_\_\_\_\_

\_\_\_ A documented history of a severe allergic reaction after a previous dose of the COVID-19 vaccine/booster

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/Medical Circumstance

\_\_\_ The physical condition of the patient or medical circumstances relating to the individual are such that immunization 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 immunization with the COVID-19 vaccine/booster.

Explanation:

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### Option 3 - Other

\_\_ 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/booster:

Explanation:

### Certification

I certify that \_\_\_\_\_ (patient name) has the above contraindication and support the request for a medical exemption from the COVID-19 vaccine/booster requirement at Teachers College.

### Provider Information

Medical Provider Name: \_\_\_\_\_

Medical Provider Specialty: \_\_\_\_\_

Signature: \_\_\_\_\_

Provider License Number: \_\_\_\_\_

Date: \_\_\_\_\_

Name of Provider Company: \_\_\_\_\_

Address: \_\_\_\_\_

Email: \_\_\_\_\_

Phone Number: \_\_\_\_\_

### Patient Information

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

UNI: \_\_\_\_\_

TC Email: \_\_\_\_\_

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Phone Number: \_\_\_\_\_