

**REQUEST FOR MEDICAL EXEMPTION FROM COVID-19 VACCINATION**

# The University of Maryland, Baltimore County is committed to building an inclusive and welcoming campus environment.

If you have an allergy to the COVID-19 vaccine or a specific medical condition that precludes the COVID-19 vaccination housing requirement and you seek a medical exemption from UMBC’s COVID-19 vaccination housing requirement, please consult with your physician and provide the following information.

**Please print the following information:**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone No.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Physician Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician Phone No.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Physician Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Dear Physician:

UMBC requires up-to-date COVID-19 vaccinations for all residential students. A medical exemption from COVID-19 vaccination is allowed for certain recognized contraindications (<https://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html>).

Please complete the form below. Thank you.

The above person should not be immunized or boosted for COVID-19 for the following reasons:

(Please check all that apply)

* Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a component of the COVID-19 vaccine
* Immediate allergic reaction of any severity to a previous dose or known (diagnosed) allergy to a component of the vaccine (Vaccine Ingredients: <https://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html#Appendix-C>)

 Which ingredient caused an allergic reaction? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 What was the reaction? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Which brand of the COVID-19 vaccine is contraindicated and why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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How long will the medical contraindication last? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Other Medical Reason – Please provide this information in a separate narrative that describes the other medical reason justifying an exemption in detail.

**FOR THE PHYSICIAN**

**I certify that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ has the above contraindication or specific medical condition and request a medical exemption from COVID-19 vaccination housing requirement.**

**Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

(Note: Signature Stamp Not Acceptable)

**Physician Medical License No.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NPI No.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***Verification and Accuracy***

**FOR THE REQUESTOR (Student/Faculty/Staff)**

I verify that the above information I have provided is complete and accurate to the best of my knowledge, and I understand that any intentional misrepresentation contained in this request may result in disciplinary action which may include suspension/dismissal. My request for an exemption from the COVID-19 vaccination housing requirement is based upon the medical reason described above. I understand that my request for an exemption may not be granted if it creates an undue hardship for the University.

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ UMBC ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Parent or Guardian (if <18 years old) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Confidentiality of Information Provided**

Requests for exemptions and any documents provided will be kept confidential and shared only with those university employees who have a need to know.

**Upload this form at https://covid19.umbc.edu/vaccine-exemption/**

***Summary of Next Steps***

1. This request will be reviewed and acknowledged by the Vaccination Exemption Review Committee. The Vaccination Exemption Review Committee may, at its sole discretion, request additional information.
2. After review, you will be notified of the decision regarding your requested medical exemption.
3. If you are granted a medical exemption, you will be required to observe all COVID-19 health and safety protocols and will be informed of any additional accommodations.
4. UMBC will reconsider a denial only if you bring forth new information supporting your request. For reconsideration of a denial, please contact the Vaccination Exemption Review Committee.

If you feel this decision by the Vaccination Exemption Review Committee violates your civil rights, you may file a discrimination complaint with the UMBC Office of Equity and Inclusion. Complaints may also be filed with the U.S. Department of Education Office for Civil Rights.