Student Request for Medical Exemption from COVID-19 Vaccination Form

Name:_____
Student ID: _____ WCCC Email: _____Phone: _____

Maine Community College System policy requires that all students provide proof of a COVID-19 vaccination before attending in-person classes beginning Fall of 2021, as communicated via this web page: https://www.mccs.me.edu/covid-19/vaccine-protocol/. A medical exemption may be granted upon receipt of a completed form (see below), signed and certified by a licensed physician, nurse practitioner or physician assistant, who is not related to and is otherwise independent from the student, and whose practice area is appropriate to the associated condition.

Any student granted an exemption will be required to take weekly COVID tests and provide the test results to a designated college official. Individuals with an approved exemption may also be required to take other preventive requirements as specified in the exemption approval, and as may be outlined by later notification and/or posting of requirements on the WCCC COVID information website.

In the event of a COVID outbreak on or near campus, individuals holding exemptions may be subject to additional restrictions, up to and including physical exclusion from campus facilities and in-person programs, until the outbreak is declared to be over.

The Accessibilities Specialist or designee will review all exemption requests, and approval is not guaranteed. After a request has been reviewed and processed, students will be notified via their college email address of the decision on their request. Due to the ongoing nature of the pandemic, the unknown nature of the future course of the COVID-19 virus, and ongoing COVID-19 medical research, approved medical exemptions will be subject to review on a semester to semester basis. In addition, approved exemptions will expire when the medical condition(s) contraindicating vaccination changes in a manner which permits vaccination.

Decisions on medical exemptions from the COVID-19 vaccination may be appealed in accordance with the college's appeal process for disability accommodations. In addition, students are permitted to reapply if new documentation and information supporting the request becomes available.

In order to submit a request, please:

- Read the CDC COVID-19 Vaccine Information at https://www.cdc.gov/coronavirus/2019-ncov/vaccines/keythingstoknow.html
- Complete this form
- Have your licensed physician, nurse practitioner or physician assistant complete the provider section of this form
- Submit the completed documents the Accessibilities Specialist. **Note:** Incomplete submissions will

not be reviewed and will be returned.

● Initial each of the following statements:

	I acknowledge that I have read the CDC COVID-19 Vaccine Information.
	I understand and assume the risks of non-vaccination during the COVID-19 pandemic.
	I understand and agree to comply with and abide by all WCCC and Maine Community College System COVID-19 policies and procedures, including COVID-19 testing and face covering requirements and other mitigation measures that may be imposed, and with guidance issued by WCCC and the Maine Community College System.
	I understand that in the event of an outbreak on campus, I may be subject to additional mitigation measures, up to and including temporary physical exclusion from WCCC facilities and sponsored activities.
	In the event I contract COVID-19 or am a close contact with a person believed or known to be infected with COVID-19, I will immediately report it to the College (via email to COVID19@WCCC.me.edu) and follow the CDC guidelines for those who are infected or a close contact, including any required isolation or quarantine period.
	I authorize my licensed health care provider to provide WCCC with my medical information necessary to support my request for a medical exemption from immunization against COVID-19, including in response to any questions that WCCC may have for the purpose of evaluating my request.
	I certify that the information I have provided in support of this request is accurate and complete as of the date of this submission.
	I understand an approved exemption may be revoked and I may be subject to disciplinary action if any false information is submitted in support of my request for a medical exemption.
	I understand that an approved exemption will be reviewed on a semester to semester basis due to the ongoing nature of the pandemic, the unknown nature of the future course of the COVID-19 virus, and ongoing COVID-19 medical research. I further understand that an approved exemption will expire when the medical condition(s) contraindicating vaccination changes in a manner which permits vaccination.

Printed Name: _____

Signature: _____

ID: _____ College Email: _____

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: _____

TO BE COMPLETED BY LICENSED PHYSICIAN, NURSE PRACTITIONER OR PHYSICIAN ASSISTANT

The Maine Community College System requires that all students receive a COVID-19 vaccination before attending live, in-person classes. _____ (insert patient's name) is requesting a medical exemption from this vaccination requirement. A medical exemption may be allowed for certain recognized contraindications.

Please select the relevant option supporting why your patient should not be immunized against COVID-19 and attach the requested explanation on your professional letterhead and in sufficient detail for independent medical review. Information provided on this form will be subject to a confidential review in consideration of the exemption request. Conditions for which the CDC does not list contraindications may be subject to independent medical review.

Option 1 - Allergy

_____ A documented severe allergic reaction (e. g., anaphylaxis) after a previous dose or to a component of the COVID-19 vaccine, or diagnosed allergy to components in each of the FDA approved immunizations. https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html#Appendix-C

- Moderna - List the component(s): _____
- Pfizer - List the component(s): _____
- Janssen/Johnson&Johnson - List the component(s): _____

____ A documented immediate allergic reaction (within four hours) of any severity after a previous dose of the COVID-19 vaccine. State the vaccine to which your patient had an allergic reaction, the date of the vaccine and nature of the reaction, and explain in detail why your patient cannot receive one of the other available vaccines.

- Moderna - Date of Vaccine & Reaction: _____
- Pfizer - Date of Vaccine & Reaction: _____
- Janssen/Johnson&Johnson - Date of Vaccine & Reaction: _____

Option 2 –Medical Condition/Circumstance

____ The patient's medical condition or circumstances contraindicate immunization against COVID-19. Describe the specific nature and probable duration of the medical condition or circumstances that contraindicate immunization against COVID-19.

Option 3 - Other

___ Explain in detail the medical condition or documented disability that you believe should exempt your patient from immunization against COVID-19, the medical basis for your professional opinion that the medical condition/disability should qualify for an exemption, and if applicable, the probable duration of the medical condition or disability.

Certification:

I certify that the information I have provided herein is true and correct and that in my professional judgment it is medically inadvisable for this individual to be immunized against COVID-19 for the reasons provided.

Provider Information:

Medical Provider Name: _____
Medical Provider Specialty/Area of Practice:_____
Signature: _____
Provider License Type and Number: _____
Date: _____
Address: _____
Email: _____
Phone Number: _____
Name of Provider's Employer: _____
Employer Contact Information (if different from above):_____
_____