

# SUNY Delhi.

## Medical Exemption from Vaccinations

A medical exemption is given when a valid contraindication to a vaccination exists. A student may submit a completed medical exemption form that is signed by a licensed physician, nurse practitioner, or physician's assistant. The provider must certify that an immunization may be detrimental to the student's health, which:

- Specifies which immunizations may be medically contraindicated;
- Contains sufficient information to determine if a medical contraindication to specific immunization exists;
- Specifies the length of time the immunization is medically contraindicated.

**COVID Vaccine contraindications are:** Documented immediate severe allergic reaction/anaphylaxis after receiving a COVID vaccine, history of thrombosis with thrombocytopenia or history of Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a confirmed SARS-CoV-2 infection or a COVID vaccine. (See the [CDC guidance regarding contraindications](#)).

*This form must be completed and signed by a licensed health care provider in New York State and must be submitted through SUNY Delhi's patient portal. Medical Exemptions are granted for no more than one year and requests must be resubmitted annually.*

### Attestation Signed by the Student

I understand that if this medical waiver is approved, in the event of a mumps, measles, rubella case, or an outbreak of COVID cases at SUNY Delhi, I may be required to leave the campus under the direction of the Department of Health for an extended period of time which may impact my ability to complete my coursework in the given semester.

**Student's Printed Name:** \_\_\_\_\_

**Student's Signature:** \_\_\_\_\_

**Date Signed:** \_\_\_\_\_

**Student's Date of Birth:** \_\_\_\_\_

**Student's SUNY Delhi 800 #:** \_\_\_\_\_

### This section is to be completed by the student's provider

As the student's health care provider, I request a medical exemption for the following required immunization(s): (check all that apply)

\_\_\_\_ COVID-19 \_\_\_ Meningitis \_\_\_ Tdap/Td \_\_\_ MMR \_\_\_ Varicella \_\_\_ Influenza

I certify under penalty of violation of NYS Public Health Law Section 2165 that the particular immunization(s) will be detrimental to the student's health.

**Explanation for exemption request for each vaccine(s).** Specify diagnosis and/or treatment precluding vaccination, date of event(s), and expected duration of contraindication. Please include supporting documentation. Attach additional pages if needed.

**COVID-19:** \_\_\_\_\_

**Meningitis:** \_\_\_\_\_

**Tdap/Td:** \_\_\_\_\_

**MMR:** \_\_\_\_\_

**Varicella:** \_\_\_\_\_

**Influenza:** \_\_\_\_\_

**Provider's Printed Name:** \_\_\_\_\_

**Provider's NYS License #:** \_\_\_\_\_

**Provider's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Provider's Phone #:** \_\_\_\_\_

**Provider's Address:** \_\_\_\_\_

**Upon completion by a licensed health care provider this form must be submitted through the SUNY Delhi patient portal. Directions below to upload completed form.**

1. Print out and complete the form.
2. Scan or take a photo of the completed form.
3. Sign into the [SUNY Delhi patient portal](#).
4. **Click on the upload link** on the menu bar at the top of the page and follow the step-by-step instructions.
5. Once uploaded, the waivers will be stored in your immunization record.
6. Waivers will be reviewed and are subject to approval.

Health Services will email the student regarding the approval of the medical vaccination waiver at their SUNY Delhi email account once reviewed.

**Student's Printed Name:** \_\_\_\_\_

**Student's Date of Birth:** \_\_\_\_\_

**Student's SUNY Delhi 800 #:** \_\_\_\_\_