



REQUEST FOR MEDICAL EXEMPTION FROM COVID-19 VACCINATION

If you have a specific medical condition that precludes the COVID-19 vaccination requirement and you seek a medical exemption from the Bradley University COVID-19 vaccination requirement, please consult with your physician and provide the following information.

Please print the following information:

Name: _____ Date of Birth: _____

Email: _____ Phone Number: _____

Physician Name: _____ Physician Phone Number: _____

Physician Address: _____

Dear Physician:

Bradley University requires COVID-19 vaccinations for all students, faculty and staff. 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 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/clinicalconsiderations.html#Appendix-C>)

Which ingredient caused an allergic reaction? _____

What was the reaction? _____

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

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 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.

By signing below, I affirm that I have reviewed the current ACIP Contraindications and Precautions and affirm that the stated contraindication(s)/precaution(s) pose a concern or could be detrimental to this individual’s health.

Physician Signature: _____ Date: _____

State of Licensure: _____ NPI Number: _____

FOR THE REQUESTOR (Student/Faculty/Staff)

I affirm that the above information I have provided is complete and accurate. I understand that, if granted an exemption, I must comply with all mitigation measures required of me by the University. Such measures include but are not limited to: participating in COVID-testing at a frequency determined by the University, wearing face covering in settings determined by the University (i.e. classrooms, labs, etc.) and maintaining certain physical distancing as determined by the University. I agree that should I contract COVID-19, I will hold the university harmless and will comply with any and all limitations placed upon me by Bradley University or public health officials. I understand that my request for an exemption may not be granted or may be rescinded if it creates an undue hardship for the University. I understand that any intentional misrepresentation contained in this request may result in disciplinary action up to and including dismissal from the University.

Signature: _____ Date: _____

Print Name: _____ BUID #: _____

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.

Next Steps:

1. This request will be reviewed and acknowledged by Bradley University (Health Services for Students, Human Resources for Faculty & Staff).
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 undergo COVID-19 testing in addition to observing all COVID-19 health and safety protocols and will be informed of any additional accommodations.