CITY UNIVERSITY OF NEW YORK
COVID-19 Vaccine Medical Exemption Request Form

Section I.
To be completed by Student or Parent/Guardian (if student is under 18)

Last Name	First Name	Date of Birth	EMPL ID #	Email

Section II.
To be completed by Medical Provider

Medical Provider certificate of contraindication: I certify that my patient (named above) should not be vaccinated against COVID-19 because they have one of the following contraindications:

Documented anaphylactic allergic reaction or other severe adverse reaction to any COVID-19 vaccine—e.g., cardiovascular changes, respiratory distress, or history of treatment with epinephrine or other emergency medical attention to control symptoms. Generally, does not include gastro-intestinal symptoms as the sole presentation of allergy. ***Describe the specific reaction:***

Documented allergy to a component of the vaccine—does not include sore arm, local reaction, or subsequent respiratory tract infection. ***Describe the specific reaction:***

Other documented contraindication. Please Explain: ***Information to be reviewed by campus Location Vaccine Authority for approval.***

Signature of Healthcare Provider:	
Name: (print)	**Clinic Stamp/License**
Phone Number:	**Email:**

Once complete, please send this form with supporting documentation to your home campus Location Vaccine Authority or upload this form with supporting documentation into CUNYFirst for approval. Note: medical exemptions are not automatically approved.