REQUEST FOR MEDICAL EXEMPTION FROM COVID-19 VACCINATION

The Pennsylvania Academy of the Fine Arts (PAFA) 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 requirement and you seek a medical exemption from PAFA's COVID-19 vaccination requirement, please consult with your physician/health care provider and provide the following information.

Please print the following information:

Student Name: _____ **Date of Birth:** _____

E-mail: _____ **Phone #:** _____

Physician Name: _____ **Physician Phone #:** _____

Physician Address: _____

Dear Physician:

PAFA requires COVID-19 vaccinations for all students seeking access to campus property. 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/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? _____

_____

_____

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.

Physician Signature: _____ **Date:** _____
(Note: Signature Stamp Not Acceptable)

Physician Medical License #: _____ **NPI No.:** _____

Verification and Accuracy

FOR THE REQUESTOR

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 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 PAFA.

Signature: _____ **Date:** _____

Print Name: _____

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 PAFA employees who have a need to know.

Summary of Next Steps

Scan and send this completed form to pafahealth@pobox.pafa.edu.

1. This request will be reviewed and acknowledged by the College. The College 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 undergo COVID-19 testing in addition to observing all COVID-19 health and safety protocols and will be informed of any additional accommodations.

4. PAFA will reconsider a denial only if you bring forth new information supporting your request. For reconsideration of a denial, please contact the Dean of Students.

If you feel this decision by the College violates your civil rights, you may file a discrimination complaint with the Office of Institutional Safety and Equity.