DukeHealth

Request for Medical Exemption from COVID-19 Vaccine Requirement

***Employee Section:* Complete the following information**

Name (last, first) _____ **Duke Unique ID**_____

Email Address: _____ **Best Phone Number** _____

After you and your provider complete this form, scan it and submit it to EOHWCovidVac@duke.edu. Information will be kept only in your confidential EOHW record.
After review and acceptance of this information, your OESO compliance record will be updated within one week.

Provider Section: **A licensed physician, PA, or NP must complete and sign this section.** Forms completed by the employee will not be accepted.

Physician/Provider Instructions: By completing this form, you certify that different methods of vaccinating against COVID-19 have been considered, and that the following medical contraindication precludes any/all vaccinations for COVID-19.
Guidance for medical exemptions for COVID-19 vaccination can be obtained from the Advisory Committee on Immunization Practices (ACIP) available at https://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html.

The following are NOT considered contraindications to COVID-19 vaccination:

- Local injection site reactions after (days to weeks) previous COVID-19 vaccines (erythema, induration, pruritus, pain, etc.)
- Expected systemic vaccine side effects in previous COVID- 19 vaccines (fever, chills, fatigue, headache, lymphadenopathy, vomiting, diarrhea, myalgia, arthralgia)
- Vasovagal reaction after receiving a dose of any vaccination
- Being an immunocompromised individual or receiving immunosuppressive medications
- Autoimmune conditions, including Guillain-Barre Syndrome
- Allergic reactions to anything not contained in the COVID-19 vaccines, including injectable therapies, food, pets, venom, environmental allergens, oral medication, latex, etc
- Breastfeeding
- Immunosuppressed person in the employee's household
- Alpha-gal Syndrome
- **The COVID vaccines do not contain Egg or gelatin, allergies to these substances are not contraindication**

Please select medically indicated contraindication below:

☐ Severe allergic reaction (anaphylaxis) after a previous dose of or to a component of the COVID- 19 Vaccine, including Polyethylene Glycol (PEG) (Please describe response in detail below and contraindication to alternatives, such as the Johnson & Johnson vaccine, which does not contain PEG)

☐ Immediate allergic reaction to a previous dose or known (diagnosed) allergy to a component of the vaccine (Please describe response in detail below and contraindication to alternative vaccines.)

☐ Other medical circumstance preventing vaccination with any available COVID-19 vaccine (Be specific and describe in detail below)

_____

_____

_____

_____

Signature of Healthcare Provider: _____ **Date**: _____

Printed name: _____ **Practice name**: _____
Practice telephone number: _____ **Practice email:**_____