OAKLAND UNIVERSITY
Covid-19 Vaccine Medical Exemption Request

To be completed by a medical provider who is a licensed and qualified D.O., M.D., Physician's Assistant, or Nurse Practitioner

OU Student Name: ____

Medical Provider Certification of Contraindication for Exemption: I certify that my patient (named above) should not be vaccinated against COVID-19 because they have one of the following contraindications as set forth by the CDC. [Complete the appropriate section and sign the bottom of the form].

☐ 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:
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☐ Documented allergy to a component of the COVID-19 vaccine – does not include sore arm, local reaction or subsequent respiratory tract infection. Describe the specific reaction:
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☐ Other documented medical condition. Explain in detail the medical condition and the reasons why you believe the patient should not receive the COVID-19 vaccine:
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Medical Provider Certification of Temporary Contraindication for Deferment: I certify that my patient (named above) should not be vaccinated against COVID-19 for the period described below due to a temporary medical condition (such as due to receipt of Monoclonal antibody or convalescent plasma for the treatment of COVID-19 in the last 90 days, pregnancy, or breastfeeding).

☐ My patient should not receive the COVID-19 vaccine until __________________ (insert date) for the following reason:____
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Signature of Healthcare Provider: _______________________________ License #_____________
Name (print): _________________________________ Phone: ___________________________
Address/Clinic Stamp: ____