COVID-19 Vaccine Exemption Form (2021)

Medical Exemption Request

☐ Employee ☐ Contractor ☐ County Employee
☐ Substitute ☐ Vendor ☐ Other: ____________________

Complete the following information. Submit the completed form, including Physician certification, to [illegible] directly or by email to [illegible]

Name (Print):____ Department:____

Classification:____ Phone Number:____

Physician Name:_______________________________________ Physician Phone Number:________________________________

I request a COVID-19 vaccine exemption due to my physician certification below. I understand I must comply with all masking/screening/testing requirements.

Signature: ____ Date:__________________________________

The section below is to be completed by the physician of the individual requesting a medical exemption.

Vaccination against COVID-19 is the most effective means of preventing infection with the COVID-19 virus, and subsequent transmission and outbreaks. It is strongly recommended that all school workers receive the vaccine. In keeping to our commitment to our students, our employees, our partners and our community and in accordance with state regulations, AESD is now requiring its employees, contractors, vendors, students, volunteers, and others to receive the COVID-19 vaccination.

Physician Certification of Exemption

I certify that my patient (patient name),____________________________should not be vaccinated against COVID-19 because of one of the following:

☐ Temporary health condition that contraindicates receiving COVID-19 vaccination. Due to this temporary health condition my patient will be eligible for the COVID-19 vaccination on (date) ______________________.

☐ Permanent health condition that contraindicates receiving COVID-19 vaccination.

☐ Documented anaphylactic allergic reaction or other severe adverse effect to a previously administered COVID-19 vaccine.

☐ Documented anaphylactic allergic reaction to a component of the vaccine including Polyethylene Glycol or Polysorbate.

☐ Deferral of vaccination requirement during my patient's high-risk pregnancy. CDC now recommends pregnant women to get vaccinated, if for medical reason you still recommend deferral, provide anticipated due date_______________________.

☐ Has been diagnosed with or treated for COVID-19 within the last 10 days. The patient's COVID-19 diagnosis or last day of treatment (whichever is later) was on (date)____.

☐ Is being actively treated or was treated with monoclonal antibodies or convalescent plasma in the past 90 days for COVID-19. The expected end date of treatment is (date)____.

Physician signature:____Print name:____

Physician medical license number:___________________________________Date:____

Risk Management/HR Use Only:

APPROVED / DENIED

Date: ___________ Notification to Employee:________________________

HR Rep: _____________________________ Signature:____