SUNY COVID-19 Vaccination Requirement
Medical Exemption Request Form –

To request a medical exemption from the SUNY COVID-19 Vaccination requirement, please complete this form, ask your licensed healthcare provider to complete the next page, and then submit this form to your campus Health Services Office.

- **Ammerman Campus:** medicalexemptammerman@sunysuffolk.edu
- **Eastern Campus:** healthserv-east@sunysuffolk.edu
- **Michael J. Grant Campus:** healthserv-west@sunysuffolk.edu

Exemption requests are evaluated on a case-by-case basis; approval is not guaranteed. Decisions will be communicated to students via their College email. If the approved exemption contains an expiration date, you will be expected to complete the vaccination requirement at that time. Should the condition continue, or a new contraindication occur, a new request with updated documentation is required. Decisions are final; however, individuals may reapply if new documentation and information should become available.

If you do not receive an exemption, you must comply with COVID-19 vaccination requirements in order to enroll in on campus classes. Please refer to MySCCC, the College website, and College communications for more detail.. Students remain subject to communicated add/drop and refund deadlines.

Part I. Student Information and Certification:

LAST NAME	FIRST NAME	STUDENT EMAIL ADDRESS	DATE OF BIRTH	STUDENT ID #

Please check each box to acknowledge:

☐ While my request is pending, I understand that I must comply with SUNY and Suffolk County Community College's COVID-19-related health and safety protocols (including but not limited to use of a face covering/mask, physical distancing, participation in weekly surveillance testing, and quarantine) applicable to unvaccinated or partially vaccinated individuals as a condition of my physical presence on campus.

☐ I certify that I have confirmed with my academic program that not receiving the COVID-19 Vaccination will not prevent the completion of my programmatic or curricular requirements.

☐ If my request is granted, I understand that I will be required to comply with SUNY and Suffolk County Community College's COVID-19-related health and safety protocols (including but not limited to use of a face covering/mask, physical distancing) if accessing College facilities as a condition of my on-going physical presence on campus. I understand that, in the event of a COVID-19 outbreak on campus, I may be excluded from all in-person classes and activities, and that if I am enrolled in courses that require a physical presence on campus, I may not be able to complete my academic coursework remotely. I acknowledge that any refund I might be entitled to in the case of a COVID-19 outbreak would be subject to all existing SUNY and College policies, as applicable.

☐ I certify that my statements above, and all supporting documentation, are true and accurate, and that the receipt of the COVID-19 vaccination may be detrimental to my health.

Student Signature*: _____ Date: _____
*Student, but Parent or Legal Guardian must sign if the student is under 18 years old as of first day of classes.

Please note that the College reserves the right to request additional documentation to support a request for a medical exemption.

Part II. Medical Exemption Request (to be completed by licensed health care provider)

A licensed health care provider (Physician, Physician's Assistant, or Nurse Practitioner) and student should review the CDC guidance regarding contraindications for COVID-19 vaccines. The provider must complete Section(s) A and/or B and provide their provider information in Section C.

Section A. Health Care Provider Certification of Contraindication: I certify that my patient (named above) cannot be vaccinated against COVID-19 because of the following contraindication:

Please select which of the medically indicated COVID-19 vaccine contraindications defined by the CDC apply:

☐ Documented severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a component of the COVID-19 Vaccine, including Polyethylene Glycol (PEG). (***Describe reaction/response below and contraindication to alternative vaccines***.)

☐ Immediate allergic reaction to previous dose or known (diagnosed) allergy to a component of the vaccine. (***Describe reaction/response below and contraindication to alternative vaccines***).

Additional details on the selected option(s) above (to be completed by the medical provider):

_____

_____

_____

_____

Please note that **NONE of the following are considered contraindications** to the COVID-19 vaccine.

- Local injection site reactions to previous COVID-19 vaccines (erythema, induration, pruritus, pain).
- Expected systemic vaccine side effects in previous COVID-19 vaccines (fever, chills, fatigue, headache, lymphedema, diarrhea, myalgia, arthralgia.
- Previous COVID-19 infection.
- 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 vaccine, including injectable therapies, food, pets, oral medications, latex etc. (Please note the COVID vaccine does not contain egg or gelatin).
- Alpha-gal Syndrome.
- Pregnancy, undergoing fertility treatment, intention to become pregnant or breast-feeding. (Please note the American College of Obstetricians and Gynecologists, the Society for Maternal-Fetal Medicine and the Society for Reproductive Medicine all strongly recommend COVID-19 vaccination during pregnancy).
- The medical condition of a family member or other residing in the same household as the employee.

Licensed Health Care Provider Certification: **By completing this form, you certify that different methods of vaccinating against COVID-19 have been fully considered and that the patient has the contraindication indicated above that precludes any/all available vaccinations for COVID-19.** Information about approved medical exemptions for COVID-19 vaccination can be reviewed at https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html.

Section B. Licensed Health Care Provider Certification of Health Condition That Makes COVID-19 Vaccination Detrimental to Student's Health (Temporary Medical Accommodation)

I certify that my patient (named above) has the following health condition that makes COVID-19 Vaccination detrimental to the patient's health at this time:

_____

Additional details on why the health condition listed above makes COVID-19 Vaccination detrimental to the patient's health and temporary medical accommodation is needed at this time (to be completed by the licensed heath care provider):

_____

_____

_____

_____

_____

The patient's health condition is:

☐ Permanent

☐ Temporary, and the expected end date is: _____

Section C. Licensed Health Care Provider Information

Provider Name: _____

Provider National Provider Identifier (NPI): _____

Provider Specialty: _____

Provider Employer/Affiliation: _____

Provider Phone: _____

Provider Signature: _____ Date of signature: _____

Physician/Provider's Stamp:

Suffolk County Community College does not discriminate on the basis of race, color, religion, creed, sex, age, marital status, gender identity or expression, sexual orientation, familial status, pregnancy, predisposing genetic characteristics, equal pay compensation-sex, national origin, military or veteran status, domestic violence victim status, criminal conviction or disability in its admissions, programs and activities, or employment. For more information and grievance procedures, please see www.sunysuffolk.edu/nondiscrimination.