UNIVERSITY AT ALBANY
State University of New York

COVID-19 Vaccine Medical Exemption Request Form

Student Name: _____ Date Of Birth_____ Albany ID: 00_____

Student must sign Part I of the form, Licensed Medical Provider must fill out and sign Part II. Upload the completed form to the Student Health Portal (https://albany.studenthealthportal.com/PyraMEDPortal).

Part I. Student Information and Certification:

I understand that the State of New York and SUNY requires, as a condition of attendance at University at Albany, submission of a certificate of immunization against COVID-19.

In consideration of this exemption, in the event of an outbreak of COVID-19 I understand that I may be asked to leave campus and suspend my studies in accordance with public health orders. Students who withdraw from the University are subject to tuition, fees, room, and board as outlined in the Financial Liability Chart regardless of steps required to be taken to mitigate COVID-19 risks.

I hereby assume all risks of personal injury to myself as a result of this exemption and also release the State University of New York, University at Albany, the State of New York and any of its personnel from all claims and damages which may arise from any impairment of health resulting to me because of this exemption up to and including death.

I understand that if I am not fully vaccinated against COVID-19, I will need to abide by all COVID-19 related health and safety restrictions if accessing a SUNY facility, including, but not limited to, pre-arrival COVID-19 testing, participating in weekly surveillance testing, use of face masks, social distancing, and isolation/quarantine of the institution and the community.

I understand that approved COVID-19 Vaccine Medical Exemptions are valid until the end of the Academic year in which they are approved. If I will be continuing my studies at UAlbany I will need to submit a new request each Academic year.

Student (Parent/Legal Guardian if under 18 years old) Signature _____Date:_____

Part II. Medical Exemption Request (to be completed by medical provider)

A licensed medical provider (Physician, Physician's Assistant, or Nurse Practitioner) and student should review the CDC guidance regarding contraindications for COVID-19 vaccines.

Medical Provider Certification of Contraindication: *I certify that my patient (named above) cannot be vaccinated against COVID-19 because of the following contraindication:*

☐ Severe allergic reaction (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.)

☐ Known (diagnosed) allergy to a component of a Covid-19 vaccine. (Describe reaction/response below and contraindication to alternative vaccines).

☐ History of Pericarditis, Myocarditis, Multisystem Inflammatory Syndrome in Children (MIS-C) or Adults (MIS-A) after a confirmed SARS-CoV-2 infection or COVID-19 vaccine. Please explain, including date of diagnosis and recent Cardiac evaluation.

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Licensed Medical Provider Information:

Clinician 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*

Provider Name (print): _____ Provider Phone:_____

Provider Signature: _____ Date: _____

Provider Specialty: _____ Provider NPI: _____

Provider Employer/Affiliation : _____