STUDENT
Exemption Request Form – Seasonal Influenza Vaccine

Section I

This section to be completed by the STUDENT requesting an exemption (Please complete all sections)

Name: _____ Date of birth

Email: _____ Contact phone number: _____

I request an exemption from the seasonal influenza vaccination. Please indicate reason and sign below:

☐ **Medical Contraindication** *I understand that by requesting an exemption due to medical contraindications I will be required to provide documentation from my primary care physician. I also understand that the medical exemption must be based on standard criteria for medical exemptions recommended by the Centers for Disease Control and Prevention or Advisory Committees on Immunization Practices. See Section II.*

☐ **Religious Reasons**

I understand that by requesting an exemption due to religious beliefs I will be required to disclose the name of my religious affiliation. See Section III.

Signature: _____ **Date:** _____

Section II

This section is to be completed by the physician of the Student requesting an exemption for medical reasons.

Dear Physician,

Influenza vaccination is the most effective method of controlling the spread of influenza, Barnard College has mandated all Students must receive a vaccine for the 2020-2021 flu season.

Your patient (named above) has requested a medical exemption. Medical exemptions are allowed based on recognized contraindications. Please complete the bottom portion of this form. If you have any questions, please contact the Primary Care Health Service, mmurphy@barnard.edu

Physician Certification of Contraindication

I certify that my patient should not be vaccinated against influenza because of the following recognized contraindications:

☐ Documented anaphylactic allergic reaction or other severe adverse effect to the influenza vaccine- e.g., cardiovascular changes, respiratory distress, or other emergency medical attention to control symptoms.
Describe the specific reaction: _____
_____
_____
_____
_____

☐ Documented allergy to a component of the vaccine – does not include allergic reaction to egg (egg-free vaccines are available), sore arm, local reaction or subsequent respiratory tract infection.
Describe the specific reaction: _____
_____
_____
_____
_____

☐ Other/ Describe the specific reason_____
_____
_____
_____
_____

Physician Signature _____ **Date_____**

Physician printed name _____ **Phone#_____**

Section III

This section is to be completed by an individual requesting a religious exemption.

Name of Religion _____

Email completed form to Primary Care Health Service @ mmurphy@barnard.edu