SACRAMENTO STATE
Student Health and Counseling Services

COVID-19 VACCINE MEDICAL EXEMPTION REQUEST

Student Name: ______________________________ Student ID #: ______________

Student Date of Birth: ______________________________ Date: ______________

I, ______________________________ (Name of licensed MD, DO, PA NP) hereby certify that the above-name student has:

☐ A medical condition that contraindicates this individual's vaccination with a COVID-19 vaccine.

Please check the appropriate box and list below either:

a) ☐ The applicable CDC contraindicates to this vaccine,* or

b) ☐ The applicable manufacturer's vaccine insert contraindication to this vaccine,* or

c) ☐ The physical condition of the person or medical circumstances relating to the person that are such that immunization is not considered safe, indicating the specific nature of the medical condition or circumstances* that contraindicate immunization with this vaccine*

***REQUIRED: Description of contraindication meeting criteria a, b, or c above**

This contraindication is: ☐ Permanent or ☐ Temporary

If Temporary, expiration date of the exemption for this vaccine is:

Signature of Medical Provider | Date | Medical License Number & State/Country of Issue

Practice Address | Provider Phone Number & Email

Students: Return this completed form to Sacramento State Student Health & Counseling Services

1. **Online:** Patient Portal https://shc-pncweb.saclink.csus.edu/ (Click on Medical Clearances/Immunization Record Update to Submit)
2. **Email:** shcs@csus.edu
3. **Fax:** (916) 720-0180

For Use by Sacramento State Student Health & Counseling Staff Only:		
☐ Date Approved:	☐ Date Denied:	☐ Date of Entry to EHR: