COMMUNITY COLLEGE OF RHODE ISLAND

COVID-19 Vaccination Medical Exemption for Students

Name:_____ **Date of Birth:** ___/___/_____ **CCRI ID:** _____
(Please print clearly) **Month Day Year**

I am aware of CCRI's COVID-19 vaccination policy for students.

I am being informed of the following:

Initial_____COVID-19 is a serious disease that has killed more than 1,000,000 people in the United States.

Initial_____COVID-19 vaccination is recommended for me and for all other members of the CCRI community to protect me and other members of the campus community from COVID-19 and its complications, including serious illness and death.

Initial_____I understand that I cannot get COVID-19 from the COVID-19 vaccines.

In choosing to request a medical exemption, I acknowledge the following:

Initial_____I understand that CCRI must approve all exemption requests and may require additional specialty evaluation as part of that process.

Initial_____I understand that individuals who are not vaccinated against COVID-19 because they received a medical exemption may be required to follow additional health and safety precautions not applicable to fully vaccinated individuals**.**

I understand that I can change my mind at any time and choose to be vaccinated against COVID.

I am requesting an exemption from vaccination because I have one of the medical contraindications to COVID-19 vaccine listed below.

- ☐ I have a documented severe allergy to each of the available vaccines.
- ☐ I am receiving immunosuppressive treatment and have been advised by my medical provider to defer vaccination to a future date.
- ☐ I have another medical condition and have been advised by my medical provider to defer vaccination to a future date.

Please include documentation from your medical provider, using the attached form, regarding the reason for your exemption request.

I have read and understand the information on this form.

Signature:_____ Date:_____

Signature:_____ Date:_____
(Parent's signature required if under 18)

Return this form and supporting materials to ContactTracing@CCRI.edu

COMMUNITY COLLEGE OF RHODE ISLAND

Student Name_____**DOB:**_____**CCRI ID:** _____

Medical Provider Documentation for COVID Vaccination Exemption Request

You have been asked to provide documentation supporting a request for medical exemption from CCRI's COVID-19 vaccination requirement for all students. Please include your medical opinion and all pertinent data supporting your opinion, as indicated below. Attach additional pages as needed.

Medical Provider Name and Title: _____

Specialty:_____**Institution/Practice Name:** _____

Contact phone number:_____**Email address:** _____

Medical condition or medication warranting exemption. Please be specific. In the event of prior vaccine reactions, please specify the vaccine and the nature of the reaction. Allergy to PEG must be documented as severe or immediate-type reaction.

Supporting data (please include any pertinent labs or studies, specialist progress notes)**:**

Exemption is temporary and vaccination can be initiated at a future date: Anticipated duration of temporary exemption: _____ ☐ Yes ☐ No

Medical Provider Name (printed): _____

Signature:_____**Date:** _____

Return this form and supporting materials to ContactTracing@CCRI.edu