**Elmhurst University**

**COVID-19 Vaccination Religious or Medical Exemption Form**

**For Students and Employees**

Name (Print Clearly): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth (mm/dd/yyyy): \_\_\_\_\_\_\_\_\_

E-mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile Phone:

***For students***:

e-Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***For employees****:*

e-Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Religious Exemptions**

Employees or students seeking an exemption from the Elmhurst University COVID-19 vaccine requirement should attach a statement detailing how the vaccine requirement conflicts with a particular, sincerely-held religious belief, practice, or observance. This statement should provide enough background and detail so that the request can be adequately evaluated. General philosophical, scientific, moral, personal, or medical objections to immunizations in general, or the COVID-19 vaccines specifically, may be recognized for the religious exemption. This statement may be authored by the employee/student or a member of the clergy familiar with the employee’s/student’s religious beliefs, practices, or observances. Statements should be uploaded to Etrieve with this completed form.

**Medical Exemptions**

Employees or students who have a specific medical condition that precludes the COVID-19 vaccination requirement and wish to seek a medical exemption from Elmhurst University COVID-19 vaccination requirement, must consult with your healthcare provider. Employees or students should complete this form, have the physician complete the Physician Form, and upload both documents to [Etrieve](https://Towson.edu/vaxexempt).

Please print the following information:

Physician Name: Physician Phone No.:

Physician Address:

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I (Employee/Student) verify that the above information as well as any attached documentation is complete and accurate to the best of my knowledge, and I understand that any intentional misrepresentation contained in this request may result in disciplinary action, which may include termination/dismissal (employees) and suspension/expulsion (students).

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:

Print Name:

Signature of Parent or Guardian (if under 18 years old)

Print Name: Date:

Confidentiality of Information Provided

Requests for exemptions and any documents provided will be kept confidential and shared only with those on the review panel.

All requests for exemptions will be reviewed by a small panel of professionals with medical and religious expertise. All identification information will be redacted when this form is reviewed by the panel. **The deadline to submit a request for an exemption is July 15, 2021**.

All identification information will be masked when this form is reviewed by the panel.

**(Physician Form)**

Dear Physician:

Elmhurst University requires COVID-19 vaccinations for all students, faculty, and staff. A medical exemption from COVID-19 vaccination is allowed for certain recognized contraindications. See [CDC – COVID-19 Vaccines for People with Underlying Medical Conditions](https://www.cdc.gov/coronavirus/2019-ncov/vaccines/recommendations/underlying-conditions.html?s_cid=10485:who%20should%20not%20take%20the%20covid%20vaccine:sem.ga:p:RG:GM:gen:PTN:FY21) for guidance.

The medical exemption request form must be completed by a licensed, treating medical provider (MD, DO, nurse practitioner, or physician’s assistant) detailing the applicable CDC contraindication for the COVID-19 vaccine

If your patient has a medical condition that should excuse them from the Elmhurst University COVID-19 vaccination requirement, please explain the circumstances in detail below under the “Additional Comments” heading.

By signing this form and including attached documentation, I attest that this patient has a medical condition for which a COVID-19 vaccination is contraindicated.

Patient Name:

Provider Name:

Provider Signature:

Date:

(Note: Signature Stamp Not Acceptable)

Provider Medical License No.:

Additional Comments: