Mandatory Vaccination (COVID and influenza)
Medical Exemption Form

Medical Exemption: per RSFH policy, a medical exemption may be granted to accommodate disabilities and for medical criteria consistent with those published by public health authorities and/or the Centers for Disease Control (CDC).

Directions: This form must be fully completed by the RSFH Workforce Member and a licensed provider - physician, physician's assistant or nurse practitioner.

RSFH Workforce Member Name: _____
RSFH Workforce Member's Signature: _____ Date: _____
RSFH Employee Number (if applicable):_____

1. **Check which this applies to: ____ Influenza; ____ COVID-19; or ____ Both**

MEDICAL CERTIFICATION (completed by your licensed provider)

2. ***For COVID-19 - I certify that (insert patient name) _____meets one or more of the following medical criteria that would prevent him or her from receiving the COVID vaccination: (check all that apply):***

____ Severe allergic reaction to Polyethylene Glycol, Polysorbate, a prior COVID-19 vaccine or other vaccine leading to include anaphylaxis requiring epinephrine treatment or treatment in a hospital, hives, swelling or respiratory distress.

____ Currently pregnant or breastfeeding (temporary exemption). Please identify the date that the temporary exemption should resolve _____.

____ Another qualifying temporary or permanent medical condition for which you recommend your patient not receive the vaccination. **Please describe (and identify the date the temporary condition should resolve, if applicable):**

[continued on the next page]

ROPER ST. FRANCIS HEALTHCARE

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3. ***For Influenza - I certify that (insert patient name) _____meets one or more of the following medical criteria that would prevent him or her from receiving the Influenza vaccination: (check all that apply):***

____ Allergy to chicken eggs, egg products or to other components of the influenza vaccine.

____ History of Guillain-Barré Syndrome within 6 weeks of receiving an influenza vaccine.

____ Another qualifying temporary or permanent medical condition for which you recommend your patient not receive the vaccination. **Please describe (and identify the date the temporary condition should resolve, if applicable):**

4. **Provider Signature:**

Check one: I am a licensed ____ Physician; ____ Physician's Assistant; or _____ Nurse Practitioner

Provider's Printed Name: _____Phone: _____

Provider's Official's Signature: _____ Date: _____

5. **Completed Forms:**

   a. **Employed RSFH Workforce Member**: Upload Completed Form to the RSFH Exemption Portal for consideration by the published exemption due date.

   b. **Non-Employed RSFH Workforce Member:** Follow the directions of your employer regarding submission and/or maintain this documentation as support for your RSFH Vaccination Attestation Form.