REQUEST FOR MEDICAL EXEMPTION TO COVID-19 VACCINE FORM

Please Print:

Name: _______________________________________ Date of Birth: ____________________

ID#: ____ Grad Year: ______________________

Please have your Primary Health Provider complete the following information below.

Diagnosis, including basis for concluding that immunization may be detrimental to student or employee's health or otherwise medically contraindicated (*Attach additional pages if your responses do not fit in text fields provided below.):*

Date of Diagnosis: ____

Date request for Medical Exemption in effect until: ______________________________________

Health Care Provider (please print):

Name: ____ Signature: ________________________

Address: ____

Phone #: ______________________________________ Fax#: ____________________________

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Health Care Provider License Number &, or Stamp:

For Pace University Health Center Use Only:

Date Received: ____

Reviewed By: ____

PLEASE COMPLETE, SIGN AND UPLOAD THIS FORM TO UNIVERSITY HEALTHCARE'S SECURE PATIENT PORTAL