

## 530-J.1 MEDICAL Exemption Request Influenza Vaccination



**Pages 1-3 REQUIRED**

**Page 1 of 3**

**Students are encouraged to consult with their medical provider in making decisions regarding vaccinations.**

Requests for a medical exemption from receiving the influenza vaccine may be initiated by submitting the completed **530-J.1 Medical Exemption Request** form (signatures must be within the past six months). All documentation confirming recognized clinical contraindications to influenza vaccination must be signed and certified by a licensed health care provider (physician, nurse practitioner or physician assistant, not related to the student), whose specialty is appropriate to the associated condition and who certifies that the influenza vaccine is detrimental to the student's health, in accordance with Centers for Disease Control and Prevention (CDC) guidelines. Completed form with associated documentation should be submitted a minimum of two weeks prior to the vaccination deadline to [exemptions@mercycollege.edu](mailto:exemptions@mercycollege.edu).

Exemption request will be reviewed by the Office of Compliance and Risk Management and student will be notified via email within five (5) business days whether the exemption request has been denied, granted temporary approval, or if additional supporting documentation is required. Temporary approval is based on Bon Secours Mercy Health (BSMH) guidelines but is subject to each clinical agency's policies and/or guidelines established in the Clinical Agency Agreement. Student will be notified by the program administrator/clinical coordinator if the exemption has been granted or denied by the clinical agency to which student has been assigned. **A reasonable attempt will be made to locate a clinical site that will accept the exemption request, but approval is granted by the clinical agency, not Mercy College; approval is not guaranteed; clinical placement is not guaranteed if student is unvaccinated. This decision is final and not subject to appeal.** Students are permitted to reapply if new documentation and information should become available.

\_\_\_\_\_  
Student Name (printed)

\_\_\_\_\_  
Student ID

☐ Yes, I have previously submitted documentation for a medical exemption for the influenza vaccine (documentation must only be provided once, but exemption requests must be submitted annually).

**If you have not yet submitted supporting medical documentation, it must be provided with this request.**

### **STUDENT ACKNOWLEDGMENT (to be completed by student)**

I am requesting an exemption from the Influenza vaccination due to my current medical condition. I understand and assume the risks of non-vaccination. I accept full responsibility for my health, thus removing liability for the required vaccinations from Mercy College or the clinical agency to which I am assigned. I understand and agree that if my medical exemption is approved, I must wear a surgical mask during direct patient care for the duration of the influenza season as determined by the local health department and the policies of the clinical agency and/or Mercy College. Approval of exemption request is subject to each clinical agency's policies and/or guidelines established in the Clinical Agency Agreement.

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date

**Office: Academic Affairs**

**Date: 8/26/22**

**Submit Completed Exemption Request and Documentation to [exemptions@mercycollege.edu](mailto:exemptions@mercycollege.edu)**

# 530-J.1 MEDICAL Exemption Request Influenza Vaccination



**Pages 1-3 REQUIRED**

Page 2 of 3

## HIPAA Authorization to Release Medical Information

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(M/D/YYYY)

Provider Name: \_\_\_\_\_

Provider Address: \_\_\_\_\_

Provider Telephone #: \_\_\_\_\_ Provider Fax #: \_\_\_\_\_

I hereby voluntarily authorize the above-named physician/healthcare professional(s), including claims administrators, service providers and consultants acting on their behalf, to release my health information to Mercy College of Ohio. By signing this document, I authorize the health care provider listed above to release pertinent health information related to the requested exemption directly to Mercy College, unless a limitation is noted below. I am authorizing this release for the purpose of providing Mercy College with sufficient information to evaluate my condition and determine whether my condition is eligible for medical exemption for mandatory vaccines. This authorization expires at the later of when: (i) my medical exemption is approved or (ii) my medical exemption is denied.

Specific description of information to be used and disclosed (only complete this line if you are only releasing some, but not all, health information):  
\_\_\_\_\_

Unless a limitation is listed on the line above, this release includes medical history, diagnosis, prognosis, and treatment plans/recommendations. The release covers all requested medical records, including those completed in connection with any other exemption request.

I understand that:

- This authorization is voluntary, and I may refuse to sign it. Refusal to sign may result in the inability to verify medical information pertaining to my exemption request.
- I may revoke this authorization at any time prior to its expiration date by sending a written revocation notice to each provider that I previously authorized to disclose health information. The revocation will not have any effect on any actions that the provider took before it received the revocation notice.
- The information that is used or disclosed pursuant to this authorization may be redisclosed by the receiving person or organization and, upon redisclosure, no longer be protected by federal privacy laws.

Student Signature \_\_\_\_\_

Date \_\_\_\_\_

\*\*\*\*\*

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. When the employee is seeking leave for a family member's serious health condition, "family medical history" is required to the extent necessary to ensure that the medical certification is complete and sufficient.

A photocopy or electronic copy of this authorization shall have the same authority as the original and may be used in place of the original.

**Office: Academic Affairs**

**Date: 8/26/22**

**Submit Completed Exemption Request and Documentation to [exemptions@mercycollege.edu](mailto:exemptions@mercycollege.edu)**

## 530-J.1 MEDICAL Exemption Request Influenza Vaccination



**Pages 1-3 REQUIRED**

Page 3 of 3

**MEDICAL EXEMPTION CERTIFICATION** (to be completed by a licensed medical provider: physician, nurse practitioner or physician assistant)

Name of Certifying Individual (please print or type): \_\_\_\_\_

Provider Address: \_\_\_\_\_

Provider Telephone #: \_\_\_\_\_ Provider Fax #: \_\_\_\_\_

I am a (check one) ☐ Licensed Physician ☐ Nurse Practitioner ☐ Physician Assistant

Office/Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

I certify that (*insert patient name*) \_\_\_\_\_ has one or more of the following medical contraindications that would prevent them from receiving the Influenza vaccination:

Check all that apply:

- ☐ Severe allergy to any component of the vaccine
- ☐ Contraindications due to medical reasons (please describe): \_\_\_\_\_
- ☐ Previous allergic reaction to product of vaccine
- ☐ History of Guillain-Barré syndrome

\_\_\_\_\_  
Signature of Certifying Individual

\_\_\_\_\_  
Date

**Office: Academic Affairs**

**Date: 8/26/22**

**Submit Completed Exemption Request and Documentation to [exemptions@mercycollege.edu](mailto:exemptions@mercycollege.edu)**