530-M.1 MEDICAL Exemption Request for all COVID Vaccinations 2021-2022
Pages 1-4 REQUIRED

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

Requests for a medical exemption from receiving any of the COVID vaccines may be initiated by submitting the completed **530-M.1** ***Medical Exemption Request*** form (signatures must be within the past six months). All documentation confirming recognized clinical contraindications to COVID-19 vaccinations 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 all COVID vaccines are 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.

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 is 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 _____

STUDENT ACKNOWLEDGMENT (to be completed by student)

Read the CDC COVID-19 Vaccine Information

☐ I request exemption from all COVID-19 vaccination requirements 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 that as I am not vaccinated, in order to protect my own health and the health of the community, I will comply with assigned COVID-19 testing requirements and/or other preventive guidance as required by the clinical agency and/or Mercy College.

☐ I understand that clinical agency policies may require me to test weekly, and I may be responsible for payment of such testing. This is an evolving situation and BSMH and other clinical agency policies are subject to change.

☐ I understand that in the event of an outbreak or threatened outbreak, I may be temporarily excluded from clinical experiences or activities. I agree to comply with these restrictions and accept responsibility for communicating with my program administrator/clinical coordinator in following compliance guidelines regarding health and safety requirements for unvaccinated individuals.

Office: Academic Affairs
Date: 12/17/21
Submit Completed Exemption Request and Documentation to exemptions@mercycollege.edu

☐ I understand my requirement to self-monitor for COVID symptoms, staying home when experiencing COVID related symptoms and/or temperatures of 100° or higher, and will follow required screening processes for the clinical agency and/or Mercy College.

☐ Should I experience any COVID-19 related symptoms and/or temperatures of 100° or higher or contract COVID-19, I will immediately report it to the College Health Nurse, Karla Vitte, at karla.vitte@mercycollege.edu, who will determine next steps based on current recommended guidance from the CDC and COVID-19 screening protocols. I will comply with all isolation and quarantine procedures specified by the College Health Nurse (and clinical agency, if applicable) and remove myself from the facilities, if so advised.

☐ I acknowledge that I have read the CDC COVID-19 Vaccine Information.

☐ I understand that this exemption will expire when the medical condition(s) contraindicating vaccination changes or if a subsequent clinical agency does not approve the exemption request.

☐ I understand and agree to comply with and abide by all COVID-19 policies and Procedures for the Clinical Agency and/or Mercy College, to include the student code of conduct.

☐ I understand that I may need to submit a new request for any subsequent changes, new medical contraindications, or on expiration of an approved exemption. I further understand that the approval is provisional based on current vaccination policies for each Clinical Agency and/or Mercy College and is subject to change based on requirements moving forward.

☐ I authorize my licensed health care provider to provide Mercy College with medical information about my medical exemption for the COVID-19 vaccination.

☐ I certify that the information I have provided in connection with this request is accurate and complete as of the date of submission. I understand this exemption may be revoked and I may be subject to a student code of conduct violation if any of the information I provided in support of this exemption is false.

STUDENT ACKNOWLEDGMENT (to be completed by student)

I am requesting an exemption from the COVID-19 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 may be required to comply with preventive requirements as specified in clinical agency policies, information listed within this exemption approval, as well as any updated recommended guidelines based on CDC recommendations. In the event of an outbreak, individuals with exemptions may be excluded from clinical experiences and activities until the outbreak is declared to be over.

Administrator Use Only

_____
Student Signature

_____
Date

Office: Academic Affairs
Date: 12/17/21
Submit Completed Exemption Request and Documentation to exemptions@mercycollege.edu

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

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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. Tocomply 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.

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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 any of the COVID vaccinations:

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