COVID-19 Vaccination Exemption Application

Directions: Please complete the COVID-19 Vaccination Declination Statement section, then complete the section that best explains your reason for requesting an exemption (medical or religious). The last section of this form must be signed by a physician (MD or DO), nurse practitioner, or physician, even for religious exemptions. (**Please note: The nurse practitioner at the Wellness Center CANNOT sign this form.**) Please email the competed form to covidexemptions@converse.edu.

PLEASE NOTE: This form is an application for an exemption. This exemption must be approved by the University. You will receive an email containing your final approval.

COVID-19 Vaccine Declination Statement

Student/employee name: _____

Student ID number (not required for employees): _____ Date of birth: _____

I understand that COVID-19 is a potentially serious disease that is spread via airborne and surface transmission. I understand that currently available vaccines greatly reduce the likelihood of developing serious illness if I contract COVID-19. The CDC, the American College Health Association, the South Carolina Department of Health and Environmental Control, and the Converse University Wellness Center strongly recommend the COVID-19 vaccine. However, I decline the COVID-19 vaccination at this time. I understand that by declining this vaccine, I will continue to be at higher risk of acquiring COVID-19. I understand that if I develop symptoms of COVID-19, I will be required to isolate myself and pursue testing to determine if I have COVID-19. If I have close contact with someone who has COVID-19, I will be required to quarantine. The duration of any quarantine or isolation periods will be in accordance with CDC guidance and University policy. During isolation or quarantine, I will be removed from all campus activities (including classes, on-campus work, and residence halls) until my isolation or quarantine period is complete.

_____ _____

Student/employee signature *Date*

_____ _____

Parent signature (if student is under 18) *Date*

COMPLETE ONE OF THE FOLLOWING TWO SECTIONS (MEDICAL OR RELIGIOUS)

If you are requesting an exemption due to MEDICAL reasons, please complete the following:

Please mark the medical concern that prevents you from receiving the COVID-19 vaccine:

- ❑ History of previous allergic reaction to indicate an immediate hypersensitivity reaction to a component of the vaccine
- ❑ A physical condition or medical circumstances that prevent me from being safely vaccinated—please describe:
- ❑ Other—please describe: _____

Please indicate if the exemption is: ❑ permanent OR ❑ temporary (please list exemption end date: _____)

_____ _____

Student/employee signature *Date*

_____ _____

Parent signature (if student is under 18) *Date*

CONTINUE TO NEXT PAGE

If you are requesting an exemption due to <u>RELIGIOUS</u> reasons, please complete the following:

I acknowledge that I am choosing not to receive the following vaccines, as they would be contrary to my genuine and sincerely held religious beliefs. By signing below, I acknowledge that I have been educated about the risks of contracting COVID-19, and the risks and benefits of vaccination. I have had an opportunity to ask questions which were answered to my satisfaction. I further acknowledge that I may be placing myself and others at risk of serious illness should I contract a disease that could have been prevented through vaccination. I feel I understand the risks associated with not receiving the COVID-19 vaccine.

In order to be considered for a religious exemption, please describe the religious beliefs that you hold that are contrary to the practice of immunization. This explanation should include enough detail that the institution can determine that these beliefs are sincerely held and consistently guide and influence your life. In your description, please address the following:

- Explain in your own words why you are requesting this religious exemption.
- Describe the religious principles that guide your objection to the practice of immunization.
- Indicate whether you are opposed to all immunizations, and if not, the religious basis that prohibits the COVID-19 vaccination.

Student/employee signature *Date*

Parent signature (if student is under 18) *Date*

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THE FOLLOWING SECTION MUST BE COMPLETED AND SIGNED BY MEDICAL PROVIDER (MD, DO, NURSE PRACTITIONER, PHYSICIAN'S ASSISTANT ONLY—MAY NOT BE WELLNESS CENTER STAFF)

Medical provider declaration statement (*Must be completed by a medical provider as listed above*)

Medical provider name: _____

Practice address: _____

Practice phone number: _____

License number: _____ State of licensure: _____

I declare the following (*please initial statements 2 and 3; initial statement 1 for medical exemptions only*):

_____ *(For medical exemptions only)* The physical condition of this individual is such that the COVID-19 vaccination would endanger their life or health; as such, the risks created by vaccination outweigh the potential benefits of preventing serious illness due to COVID-19.

_____ I have educated this individual on the dangers of the SARS-COV-2 virus and the potential adverse health outcomes resulting from COVID-19 as a condition for exemption.

_____ I have educated this individual on the risks and benefits of the COVID-19 vaccine as a condition for exemption.

By signing below, I certify that the statements I have initialed above are accurate and true. I have provided this individual with sufficient information to make an informed decision on COVID-19 vaccination. (*Medical provider signature required*.)

_____ _____

Medical provider signature *Date*