DEPARTMENT OF ADMINISTRATIVE SERVICES

Request for Medical Exemption for COVID-19 Vaccination

Covered State Agencies, School Boards, or Child Care Facilities may exempt an individual from the facility's COVID-19 vaccination requirement if the individual's physician (MD or DO), physician assistant (PA), or advanced practice registered nurse (APRN) determines that the administration of the COVID-19 vaccine is likely to be detrimental to the individual's health. In such cases, the facility may allow the individual to continue to access on-site facilities if the individual:

1. is able to perform their essential job functions with a reasonable accommodation that is not an undue burden on the facility,
2. does not pose a direct threat to the health or welfare of others, and
3. submits adequate proof of a negative test for SARS-CoV-2 on a weekly basis

To request a medical exemption to the COVID-19 vaccination requirement, please complete the information below and have your physician, physician assistant, or advanced practice registered nurse complete the information on the pages that follow. Once the form is completed, please submit it to the individual designated by the facility.

EMPLOYEE REQUESTING EXEMPTION:

Name: _____ Date of Birth: _____

Job Title: _____ Employee Number: _____

Agency/Department: _____

Manager/Supervisor: _____

Email: _____ Cell Phone: _____

Home Phone: _____ Work Phone: _____

HEALTHCARE PROVIDER CERTIFICATION

Patient Name: _____

Dear Healthcare Provider:

The above-named individual has requested a medical exemption from COVID-19 vaccination. This request for exemption will be evaluated based on the medical information you provide. A medical exemption is allowed only for currently recognized contraindications or other compelling medical reasons.

We encourage you to listen carefully to your patient's concerns regarding vaccination and provide information that will help them make a fully informed decision. The CDC also provides information that is helpful in overcoming vaccine hesitancy. For some patients, specialists in allergies and immunology may be able to provide additional care and advice. Please include any related medical information connected to your assessment.

Please complete this form if the person listed above seeking a medical exemption is your patient, you agree that this patient has medical contraindications to receiving all currently available COVID-19 vaccines, and you recommend that this patient should **NOT** be vaccinated for COVID-19 based on their individual medical condition(s). More information on clinical considerations for COVID-19 vaccination, including contraindications, can be found on the CDC website: https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html.

Directions:

Part 1. Please complete the Provider Information requested.

Part 2. Please mark the currently recognized contraindications/precautions that apply to this patient (indicate all that apply).

Part 3. If no contraindications or precautions apply in Part 2 but you are still indicating a need for medical exemption from COVID-19 vaccination for this patient, provide a brief explanation of your reasoning for this opinion.

Part 4. Read, sign, and date the Statement of Clinical Opinion.

Patient Name: _____

Part 1. Provider Information:

Physician (MD or DO)/Physician Assistant/Nurse Practitioner (APRN) Name *(print)**:***

_____

Name and Address of Practice:

_____

Contact Phone Number: _____ ***Email:*** _____

State License Number: _____

Part 2. Specific Contraindications

Medical contraindications and precautions for COVID-19 vaccine are based upon the Advisory Committee on Immunization Practices (ACIP) Interim Clinical Considerations for Use of COVID-19 Vaccines Currently Approved or Authorized in the United States, published by the Centers for Disease Control and Prevention.

A **contraindication** is a condition in a recipient that increases the risk for a serious vaccine adverse event (VAE) or compromises the ability of the vaccine to produce immunity.

A **precaution** is a condition in a recipient that might increase the risk for a serious VAE or that might compromise the ability of the vaccine to produce immunity. Under normal conditions, vaccinations are deferred when a precaution is self-limiting, but can be administered if the precaution condition improves.

Neither contraindications nor precautions to COVID-19 vaccination

Allergic reactions (including severe allergic reactions) not related to vaccines (COVID-19 or other vaccines) or injectable therapies, such as allergic reactions related to food, pet, venom, or environmental allergies, or allergies to oral medications (including the oral equivalents of injectable medications), are **not** a contraindication or precaution to COVID-19 vaccination. The vial stoppers of COVID-19 vaccines are not made with natural rubber latex, and there is no contraindication or precaution to vaccination for people with a latex allergy. In addition, because the COVID-19 vaccines do not contain eggs or gelatin, people with allergies to these substances do not have a contraindication or precaution to vaccination.

Delayed-onset local reactions have been reported after mRNA vaccination in some individuals beginning a few days through the second week after the first dose and are sometimes quite large. People with only a delayed-onset local reaction (e.g., erythema, induration, pruritus) around the injection site area after the first vaccine dose do **not** have a contraindication or precaution to the second dose. These individuals should receive the second dose using the same vaccine product as the first dose at the recommended interval, preferably in the opposite arm.

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Please mark the vaccine(s), exemption duration, and all contraindications/precautions that apply to this patient for each vaccine.

CDC Recognized Contraindications and Precautions

COVID-19 Vaccines included in exemption	**Exemption Duration**	**ACIP Contraindications and Precautions** *(Check all that apply)*
☐ **Pfizer mRNA vaccine** ☐ **Moderna mRNA vaccine** ☐ **Janssen/ J&J viral vector vaccine**	☐ **Temporary through: ____/_____ mm/ yyyy** ☐ **Permanent**	**Contraindications** ☐ Severe allergic reaction* (e.g., anaphylaxis) after a previous dose or to a component of the COVID-19 vaccine ☐ Immediate allergic reaction* of any severity to a previous dose or known (diagnosed) allergy to a component of the COVID-19 vaccine **Precautions** ☐ History of an immediate allergic reaction* to any vaccine other than COVID-19 vaccine ☐ History of an immediate allergic reaction* to any injectable therapy (i.e., intramuscular, intravenous, or subcutaneous vaccines or therapies [excluding subcutaneous immunotherapy for allergies, i.e., "allergy shots"]) ☐ History of an immediate allergic reaction* to a vaccine or injectable therapy that contains multiple components, one or more of which is a component of a COVID-19 vaccine, have a precaution to vaccination with that COVID-19 vaccine, even if it is unknown which component elicited the allergic reaction

* Immediate allergic reaction to a vaccine or medication is defined as any hypersensitivity-related signs or symptoms consistent with urticaria, angioedema, respiratory distress (e.g., wheezing, stridor), or anaphylaxis that occur within four hours following administration.

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Patient Name: _____

Part 3. Other Medical Condition Necessitating Exemption

If claiming the need for a medical exemption from COVID-19 vaccination for this patient based on a condition that does not meet any of the ACIP criteria for a contraindication or precaution listed in Part 2, provide an explanation of your reasoning for this opinion below.

PLEASE NOTE: ONLY state employees with a state Employee ID #, or others with specific direction (please see https://portal.ct.gov/sevi can submit information to WellSpark. State contractors do not submit forms to WellSpark.

If you are a state employee with a state employee ID number, and you do not have access to a smartphone or computer, you can submit your information via email at Statecovid@wellsparkhealth.com or fax to 860-678-5207 or 860-678-5229. All others who do not have access to a smartphone or computer should consult with their supervisor or human resources department. If you have filed for a medical or religious exemption, you are not considered compliant until that exception is officially approved upon review. Please be reminded that you must submit weekly testing results.

PROVIDER CERTIFICATION: I certify that the _____
above-named individual should be granted a medical exemption from COVID-19 vaccination because I have reviewed the clinical considerations for COVID-19 vaccination and accordingly have determined that the administration of a COVID-19 vaccine would be detrimental to the individual's health. I understand that it is a crime under Connecticut State law to provide false information punishable pursuant to Section 53a-157b of the Connecticut General Statutes by a fine of not more than $2,000 or imprisonment of not more than one year.

Signature: _____ **Date:** _____