Hamilton

The Joel and Elizabeth Johnson Center for Health and Wellness

REQUEST FOR MEDICAL EXEMPTION TO COVID-19 VACCINE FORM

Please Print:

Student Name: _____ Date of Birth: _____

Student 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 your health or otherwise medically contraindicated:

_____

_____

_____

_____

_____

_____

Date of Diagnosis: _____

Medical Exemptions are valid for one year from the date listed. They need to be submitted annually for review in advance of the upcoming academic year.

Health Care Provider (please print):

Name: _____ Signature: _____

Address: _____

Phone #: _____ Fax#: _____

I certify that _____ has the above contraindication and request a
(Student Name)
medical exemption from the COVID-19 vaccination requirement of Hamilton College.

_____

For Hamilton College Health Center Use Only:

Date Received: _____

Reviewed By: _____