Center for Health & Counseling Services

Health Services
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COVID 19 VACCINE MEDICAL EXEMPTION FORM

Last Name	First Name	Middle Initial	Date of Birth	Ramapo ID

Medical Provider Certification of Contraindications: I certify that my patient (named above) should not be vaccinated against COVID-19 because they have one of the following contraindications:

____ Documented anaphylactic allergic reaction or other severe adverse reaction to any COVID-19 vaccine – e.g., cardiovascular changes, respiratory distress or history of treatment with epinephrine or other emergency medical attention to control symptoms. This does not include gastrointestinal symptoms as the sole presentation of allergy. Please describe the specific reactions: ____
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____ Documented allergy to a component of the vaccine. This does not include a sore arm, local reaction or subsequent respiratory infection. Please describe the specific reaction and the component of concern:
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____

____ Other documented contraindication. Please explain fully as this information may be reviewed by an infectious disease consultant prior to approval.____
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THIS FORM MUST BE COMPLETED & SIGNED BY YOUR HEALTH CARE PROVIDER:

Medical Provider Signature ___________________________________ Date ____________
License Number ______________________________ or Office Stamp Required