BAYLOR UNIVERSITY

Practicum/Internship Attestation for Affiliate Agency
COVID-19 Vaccine Medical Exception Form

Request For: COVID 19 VACCINE MEDICAL EXCEPTION FORM

Name of Student: ID#	Date of Birth:
Name of Parent/Guardian (if under 18): first/middle/last	Primary Phone:
Patient/Parent Home Address: address 1 address 2 city state zip	
Patient/Parent Email Address:	

Medical contraindications and precautions for immunizations are based on the most recent General Recommendations of the Advisory Committee on Immunization Practices (ACIP)/CDS, available at https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html or https://www.cdc.gov/vaccines/covid-19/index.html
Please check the website to ensure that you are reviewing the most recent CD/ACIP information. Please note that the presence of a moderate to severe acute illness with or without fever is a precaution to administration of all vaccines. However, as acute illnesses are short-lived, medical exemptions should not be submitted for this indication.

Table 1. ACIP Contraindications and Precautions to Vaccination for Mandatory Vaccines

Vaccine	Exemption Length	ACIP Contraindications and Precautions
COVID 19 Vaccine	☐ **Temporary through:** ☐ ☐ **Permanent**	**Contraindications** ☐ **Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component** ☐ **Other (explain below)**
Other	**Please explain fully and attach additional sheets as necessary.**	

Attestation

I am a physician (M.D. or D.O.) licensed to practice medicine in a jurisdiction of the United States or an advanced practice nurse or physician assistant licensed in a jurisdiction of the United States.

By signing below, I affirm that I have reviewed the current CDC/ACIP Contraindications and Precautions, and I also affirm that the stated contraindication(s)/precaution(s) is enumerated by the CDC/ACIP and consistent with established national standards for vaccination practices. I understand that I might be required to submit supporting medical documentation.

Healthcare Provider Name (please print): _____ Specialty:_____

NPI Number:_____License Number:_____State of Licensure:_____

Phone:_____Fax:_____Email:_____

Address:_____City:_____State:_____Zip:_____

Signature:_____Date:_____