Manhattan College COVID-19 Immunization
Booster Medical Exemption Statement

Note: This form applies only to the COVID-19 booster immunization required for college attendance or employment

A board-certified, state **licensed physician or nurse practitioner** must complete this medical exemption statement, provide their information and retain a copy as part of the patient's medical record.

Healthcare Provider Instructions:

1. *Complete patient information (name, DOB, etc.).*
2. *Indicate which vaccine(s) booster the medical exemption is referring to.*
3. *Complete contraindication and/or precaution information.*
4. *Complete date the exemption ends, if applicable. If not indicated, the exemption will expire at the end of the semester.*
5. *Complete your healthcare provider information.*

Patient's Name: ____

Patient's Date of Birth: ____

Patient's Address: ____

Patient's Phone Number: ____

Please indicate which vaccine(s) booster the medical exemption is referring to:

☐ Pfizer-BioNTech ☐ Moderna ☐ Johnson & Johnson's Janssen

Please describe the patient's booster medical contraindication(s) here (e.g., documented anaphylactic allergic reaction or other severe adverse reaction to any vaccine; documented allergy to a component of the vaccine; other contraindication). This contraindication(s) must be consistent with the CDC and FDA:

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Please describe how booster immunization may be detrimental to the patient's health (precaution information) here:

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Date exemption ends (if applicable): ____________________

Healthcare Provider Name (print): ____

State and Medical License #: ____

Office Address: ____

Contact number: ____

Signature: ____ Date: ______________