Manhattan College COVID-19 Immunization Medical Exemption Statement

Note: This form applies only to COVID-19 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) 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 academic year.
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) the medical exemption is referring to:

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

Please describe the patient's 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 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: ____________________