I, ________________________________, am a Manhattan College student. I understand that Manhattan College requires that all Manhattan College students demonstrate proof of full COVID-19 vaccination, which includes a full series of vaccines and a booster shot by **June 15, 2022 (Summer) and August 1, 2022 (Fall/Spring)**. I hereby request an exemption from Manhattan College’s proof of full COVID-19 vaccination requirement based upon the following reason:

Sincerely Held Religious Belief Contrary to the Practice of Vaccination

I understand that any student seeking or renewing a religious exemption to the proof of full COVID-19 vaccination must provide Manhattan College with a completed and signed religious exemption request form (see attached form) providing statements and a religious leader's signature. The student is also required to discuss with and obtain a signature of a healthcare provider (see below) who has informed them of the risks of COVID-19.

I understand that in the event of an outbreak of vaccine preventable disease, all susceptible students may be excluded from school settings based on public health officials’ determination that the school is a significant site for disease exposure, transmission and spread into the community. Students without proof of immunity, including those with religious exemptions shall be excluded from these settings for this reason and will not be able to return until (1) the danger of the outbreak has passed as determined by public health officials, (2) the student becomes ill with COVID and is no longer contagious, or (3) the student is immunized.

I understand that the College will aim to provide a reasonable academic accommodation for any absences due to COVID-19 disease, however, the College will not be responsible for any costs or expenses due to missed classes or exclusion from housing or campus resources during any period of communicability. I further understand that, by requesting an exemption, I agree to release Manhattan College from any cost or liability associated with any COVID-19 related illness or injury and I will not be entitled to a refund of any costs incurred during any quarantine periods on- or off-campus.

I agree to follow any College COVID-19 prevention program that may be in effect during the semester, including: testing, mask wearing, quarantine, and completing the Daily Symptom Tracker when on campus. I further understand that if testing is a requirement, the College will not be responsible for any testing costs.

DATE: _______ Student Signature: ____________________________________________________________

DATE:_______ Parent/Guardian Signature (if student is under 18): __________________________________

Healthcare Provider: Please complete the information below and acknowledge that you have discussed with and informed the student of the risks of COVID-19:

Healthcare Provider Name (print): _________________________________________________________

State and Medical License #: __________________________________________________________________

Office Address: _____________________________________________________________________________

Contact number: _____________________________________________________________________________

Signature: _____________________________________________________________________________ Date: ________________________