COVID 19 VACCINE MEDICAL EXEMPTION FORM

Employee Name	Date of Birth
Primary Phone	Email Address
Home Address:	

Medical contraindications and precautions for immunizations are based on the most recent General Recommendations of the Advisory Committee on Immunization Practices (ACIP)/CDC, available at https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html or https://www.cdc.gov/vaccines/covid-19/index.html or https://redbook.solutions.aap.org/redbook.aspx Please check the website to ensure that you are reviewing the most recent CDC/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 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)

Vaccine	**Exemption Length**	**CDC/ACIP Contraindications and Precautions**
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 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 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:_____

Clinic or Facility:_____ State of Licensure:_____

Phone:_____ Fax:_____ Email:_____

Address:_____ City:_____ State:_____ Zip:_____

Signature: _____Date:_____

COVID 19 VACCINE RELIGIOUS EXEMPTION FORM

Employee Name	Date of Birth
Primary Phone	Email Address
Home Address:	

Explain in your own words why religious belief and practices prevent you from complying with the Northeast South Dakota Head Start Program's required vaccination policy.

Identify your specific religious belief(s) and practices that prevents you from receiving the COVID-19 vaccination.

Verification and Accuracy

I have read and understand the Company's policy on required COVID-19 vaccines. By my signature below, I verify that my religious beliefs and practice is sincerely held. I understand that the organization my request further information from me regarding my sincerely held religious belief and practice to further evaluate my request for an exemption from receiving the COVID-19 vaccination. I understand that any intentional misrepresentation contained in this request may result in disciplinary action.

_____

Name (Printed)

_____ _____

Signature Date