LINCOLN SCHOOL

PROVIDENCE

Request for Medical Exemption from COVID-19 Vaccination

This form must be completed and signed by a Rhode Island licensed physician, not related to the submitter. Medical exemptions are granted for no more than one year and requests must be resubmitted annually. Diane Murphy will review all medical exemption requests and may request additional information. Parental concerns will not be considered without medical documentation.

Student's Information:

Name:	Date of Birth:
Grade (for 2022-2023 school year):	Date of Request:

I verify that the information I am submitting to substantiate my request for an accommodation or exemption from the School's COVID vaccination policy is true and accurate to the best of my knowledge. I further understand that the School is not required to provide this accommodation if doing so would pose a direct threat to my child or others in the School or would create an undue hardship for the School. Also, if exemption is approved, I understand that my child will be required to comply with additional testing and other preventive requirements, and may be precluded from participating in certain activities. In the event of an outbreak on or near campus, my child may be excluded from all campus facilities and activities, for their protection, until the outbreak is declared to be over.

I authorize (physician name) to provide the School with information contained in my child's medical record, including, but not limited to laboratory or other records supporting this request.

Parent/Guardian Signature:	Date:

Medical Exemption Request

For more information please see:

https://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html#CoV-19-vaccination

As the student's healthcare provider, I request a medical exemption for (student name) date of birth_ _/_ _/ _ _ _ _ for the COVID-19 immunization which is required by the School. I certify that this immunization will be detrimental to the child's health.

Explanation for exemption request for the vaccine.

Option 1 - Allergy

__ A documented history of a severe allergic reaction to any component of a COVID-19 vaccine or to a substance that is cross-reactive with a component. Please indicate which of the following vaccines are contraindicated and name the components, by vaccine. NOTE: since egg free vaccine is available, history of egg allergy will not be accepted as a routine medical exemption.

Moderna List the component(s):

Pfizer List the component(s):

Janssen/ J&J List the component(s):

__ A documented history of a severe allergic reaction after a previous dose of the COVID-19 vaccine. Please indicate which vaccine caused a significant reaction in the patient and the date of the vaccine & reaction:

Date of Vaccination: _____

Name of Vaccine: _____

Nature of Reaction: _____

Option 2 – Physical Condition/Medical Circumstance

__ The physical condition of the patient or medical circumstances relating to the individual are such that immunization is not considered safe. Specify diagnosis and/or treatment precluding vaccination, date of event(s), and expected duration of contraindication. Please include supporting documentation. Attach additional pages if needed.

I certify the above information to be true and accurate, and request exemption from the COVID-19 vaccination for the above-named individual.

Medical Provider Name (print):

Medical Provide Signature:	Date:
Practice Name & Address:	Provider Phone: