State University of New York at Fulton-Montgomery Community College (FMCC)

COVID-19 Vaccination / Booster Requirement
Medical Exemption Request Form for Spring 2022

Please read and follow all instructions to avoid delay or completion of the request.
Submission Deadline:
May 23rd for the first Summer 2022 session. June 27th for the second Summer 2022 session.
August 26th for Fall 2022.

To request a medical exemption from the SUNY COVID-19 vaccination mandate, you must complete this form (including any certification), use your own FMCC email (or via personal email for students who have been admitted but not yet enrolled) and submit it to registrar@fmcc.suny.edu.

Include in Email Subject Line your Full Name and “Medical Exemption”.

If you do not use the registrar@fmcc.suny.edu email address, do not complete the form in full or do not file by the deadline, your request will not be processed.

Per SUNY Policy, all students who plan to attend in-person classes and/or utilize in-person services at a SUNY facility or campus must provide evidence of receiving a full vaccination series (i.e., both doses of a two-dose series) of any COVID-19 vaccination or apply for an exemption.

A decision regarding your request will be released through FM student email if a current student or via personal email for students who have been admitted but not yet enrolled.

Part I. Student Information and Certification:

<table>
<thead>
<tr>
<th>LAST NAME</th>
<th>FIRST NAME</th>
<th>STUDENT EMAIL ADDRESS</th>
<th>DATE OF BIRTH</th>
<th>STUDENT ID #</th>
</tr>
</thead>
</table>

Please check each box to acknowledge:

☐ While my request is pending, I understand that I must comply with the campus’ COVID-19 related health and safety protocols (e.g., masks/face coverings, social distancing, regular surveillance testing) applicable to unvaccinated or partially vaccinated individuals as a condition of my physical presence in a SUNY Facility.

☐ I certify that I have confirmed with my academic program that not receiving the COVID-19 Vaccination will not prevent the completion of my programmatic or curricular requirements.

Name of Academic Program:

☐ If my request is granted, I understand that I will be required to comply with the campus’ COVID-19 related health and safety protocols (e.g., mask/face coverings, social distancing, regular surveillance testing) if accessing a SUNY Facility as a condition of my on-going physical presence. I am aware that should a COVID-19 outbreak occur at the campus that I may be excluded from all in-person classes and activities and that if I am enrolled in courses that require a physical presence on campus that I may not be able to complete my academic coursework remotely. I acknowledge that any refund I might be entitled to in the case of a COVID-19 outbreak would be subject to all existing SUNY policies.

☐ If my request is granted and I fail to continue to comply with the campus’s COVID-19 related health and safety protocols, I can face Student Code of Conduct charges. Outcomes for such violations can range from verbal warnings to termination of exemptions to removal from face-to-face coursework and on-campus presence, and administrative withdrawal.
☐ If my request is granted, I understand that I am fully responsible for my health, and I fully assume any and all risks associated with not receiving immunizations/vaccinations and that Fulton-Montgomery Community College cannot be held responsible for my actions in this matter.

☐ If my request is granted, I understand that the exemption applies only to Fulton-Montgomery Community College and not to any other organization or program. The exemption will not apply in any internship/externship/clinical rotations or placements that may require specific immunizations/vaccinations or policies.

☐ I certify that my statements above, and all supporting documentation, are true and accurate.

Signature*: _________________________________________ Date: ____________

*Student, but Parent or Legal Guardian must sign if the student is under 18 years old as of first day of classes.

Please note that the campus reserves the right to request additional documentation to support a request for a medical exemption.

Works Cited:
Part II. Medical Exemption Request (to be completed by medical provider)

A licensed medical provider (Physician, Physician’s Assistant, or Nurse Practitioner) and student should review the CDC guidance regarding contraindications for COVID-19 vaccines. The provider must complete Section(s) A and/or B and provide their provider information in Section C.

Section A. Medical Provider Certification of Contraindication: I certify that my patient (named above) cannot receive the COVID-19 vaccination booster because of the following contraindication:

Please select which of the medically indicated COVID-19 vaccine contraindications defined by the CDC apply:

☐ Severe allergic reaction (anaphylaxis) after a previous dose or to a component of the COVID-19 Vaccine, including Polyethylene Glycol (PEG). *(Describe reaction/response below and contraindication to alternative vaccines.)*

☐ Immediate allergic reaction to previous dose or known (diagnosed) allergy to a component of the vaccine. *(Describe reaction/response below and contraindication to alternative vaccines.)*

Additional details on the selected option(s) above are required and must be completed by the medical provider:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Please note that NONE of the following are considered contraindications to the COVID-19 vaccine.

- Local injection site reactions to previous COVID-19 vaccines (erythema, induration, pruritus, pain).
- Expected systemic vaccine side effects in previous COVID-19 vaccines (fever, chills, fatigue, headache, lymphedema, diarrhea, myalgia, arthralgia).
- Previous COVID-19 infection.
- Vasovagal reaction after receiving a dose of any vaccination.
- Being an immunocompromised individual or receiving immunosuppressive medications.
- Autoimmune conditions, including Guillain-Barre Syndrome.
- Allergic reactions to anything not contained in the COVID-19 vaccine, including injectable therapies, food, pets, oral medications, latex etc. *(Please note the COVID vaccine does not contain egg or gelatin.)*
- Alpha-gal Syndrome.
- Pregnancy, undergoing fertility treatment, intention to become pregnant or breast-feeding. *(Please note the American College of Obstetricians and Gynecologists, the Society for Maternal-Fetal Medicine and the Society for Reproductive Medicine all strongly recommend COVID-19 vaccination during pregnancy.)*
- The medical condition of a family member or other residing in the same household as the employee.

Clinician Certification: **By completing this form, you certify that different methods of vaccinating against COVID-19 have been fully considered and that the patient has the contraindication indicated above that precludes any/all available vaccinations for COVID-19.** Information about approved medical exemptions for COVID-19 vaccination can be reviewed at [https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html](https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html)
Section B. Medical Provider Certification of Disability That Makes COVID-19 Vaccination Booster Inadvisable

“Disability” is defined as any impairment resulting from anatomical, physiological, genetic, or neurological conditions which prevents the exercise of a normal bodily function or is demonstrable by medically accepted clinical or laboratory diagnostic techniques and any other condition recognized as a disability under applicable law.

“Disability” may include pregnancy, childbirth, or a related medical condition where reasonable accommodation is medically advisable.

I certify that my patient (named above) has the following disability that makes COVID-19 Vaccination Booster inadvisable:

________________________________________________________________________________________

Describe additional details on why the disability listed above makes COVID-19 Vaccination Booster Inadvisable. This must be completed by the medical provider:

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

The patient’s disability is:  □ Permanent
  □ Temporary

If temporary, the expected end date is: ___________________________

Section C. Medical Provider Information

Provider Name: _________________________________________________________________

Provider National Provider Identifier (NPI): __________________________________________

Provider Specialty: ______________________________________________________________

Provider Employer/Affiliation: _______________________________________________________

Provider Phone: __________________________________________________________________

Provider Signature: ____________________________ Date of signature: _________________