COVID-19 Vaccination Requirement
Medical Exemption Request Form
for Students

Student Name: ____________________________ Emory ID #: ___________________________

Please write your initials in the space next to “Acknowledged” to confirm that you have read and understand that statement.

Emory School of Medicine requires COVID-19 vaccination of our students to prevent COVID-19 and its complications, including death. Acknowledged _________

Due to my role, if I am unvaccinated and do not follow masking and social distancing guidelines, I may give COVID-19 to my patients, my teammates, my family and/or friends, even if I have no symptoms. Acknowledged _________

I have received education about the effectiveness of COVID-19 vaccinations, as well as possible adverse events. Acknowledged _________

I cannot get COVID-19 from the COVID-19 Vaccine. Acknowledged _________

I acknowledge my responsibility to only request a medical exemption if truly necessary. Acknowledged _________

Even though I can receive the COVID-19 vaccine at no charge, I want a medical exemption from taking the COVID-19 vaccine. Acknowledged _________

Do you provide direct patient care? (Please select a response): Yes __________ No__________

Has Emory University or Emory Healthcare granted you an exemption from any other mandatory vaccine requirement in the past? Yes ____________ No_____________

List Exemption Reason:

_____ I have severe, life-threatening allergies to the COVID-19 vaccine or an ingredient in the vaccine.

_____ I have had a severe, life-threatening prior reaction to the COVID-19 vaccine.

_____ I have a current medical condition that prohibits me from obtaining the COVID-19 vaccine.

Please describe that condition below:

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
A signature from a licensed healthcare provider is required to validate a medical contraindication that does not allow you to get the COVID-19 vaccine.

Physician Signature/Date:

____________________________________________________________________

Physician Name (Please Print):

____________________________________________________________________

Physician Contact Phone Number: ________________________________________

To be considered for a medical exemption, you must provide documentation from a licensed healthcare provider supporting your request. This should include medical records with the reaction or other medical reason for the exemption. Please submit your documentation with this completed form. Requests will not be considered without documentation.

I understand that my request may not be granted if it is unreasonable, creates undue risk to patient safety or if it creates an undue hardship on my school. Acknowledged ______________

Date: _______________________________    Emory ID #: __________________________
Print Name: __________________________    Signature _____________________________

Please upload this form into the School of Medicine exemption application once completed.