Whitworth University Health Center
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Whitworth University COVID-19 (SARS-CoV-2) Vaccination
Medical Exemption Request Form – Student

Student Name (Print):		Whitworth I.D.#:	
Date of Birth (mm/dd/yyyy)		Home/Cell Phone #:	

Medical Exemption Options: This form is for students who are requesting a medical exemption from Whitworth University's (Whitworth) COVID-19 vaccination requirements.[1] There are two options available to students for a medical exemption; both of these options require the signature of a healthcare provider. Please see Section 1. Medical exemptions will remain in place for one academic year and must be renewed annually.

SECTION 1: TO BE COMPLETED BY A HEALTHCARE PROVIDER

Healthcare Provider Declaration

I declare that the above-named patient, _____, consulted with me on whether they should be vaccinated for COVID-19 (SARS-CoV-2). I have discussed the benefits and risks of immunizations with the patient and/or parent/legal guardian as a condition of exemption. I certify that I am a qualified healthcare provider (MD, DO, ARNP, PA, ND) and the information provided on this form is complete and correct.

Provider Name (Print)		Provider's National Provider Identifier (NPI) (required)	
Provider Signature		Clinic Address	

[1] Whitworth will require students who learn, work or live on any Whitworth campus location to be fully vaccinated for COVID-19 prior to the start of the fall 2021 academic term. Individuals will be able to request an exemption. "Fully vaccinated" means receiving two doses of the Pfizer or Moderna COVID-19 vaccine or one dose of the Janssen/Johnson & Johnson COVID-19 vaccine. Full effectiveness is on the 15th day after the last dose. Whitworth will accept any vaccine approved by the World Health Organization.

Date (mm/dd/yyyy)		Provider's Office/Work Phone	

Healthcare provider should initial the appropriate box below. <u>Please initial only one:</u>

□ <u>Option 1</u>: Vaccination for COVID-19 is not advisable for this patient for medical reasons as identified within the Centers of Disease Control and Prevention (CDC) contraindications.[2] **<u>Please provide an explanation below</u>**. ***Healthcare Provider Initial*** _____

This contraindication is:[3]

□ Permanent

□ Temporary. If temporary, what is the expiration date of the exemption for the COVID-19 vaccine(s)?: _____.

Comment: _____

_____

_____

_____

□ <u>Option 2</u>: The patient has health concerns about the COVID-19 vaccines and has discussed those with me. I verify that I have consulted with the patient on the risks and benefits of the COVID-19 vaccines as they relate to the patient's health concerns associated with receiving the COVID-19 vaccines. ***Healthcare Provider Initial*** _____

[2] CDC, Interim Clinical Considerations for the use of COVID-19 Vaccines, https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html.

[3] The CDC notes that "Because the majority of contraindications are temporary, vaccinations often can be administered later when the condition leading to a contraindication no longer exists."

SECTION 2: TO BE COMPLETED BY STUDENT

Student or Parent/Guardian (only if student is under age 18) Declaration

I have received and reviewed information on the risks and benefits of the SARS-CoV-2 (COVID19) vaccine with my healthcare provider.

Student's Name (Print)	
Student's Signature	

Parent/Guardian Signature if Under Age 18	
Date (mm/dd/yyyy)	

Student must read the following and initial and sign:

1) I understand that COVID-19 is a serious viral illness and the Centers for Disease Control and Prevention (CDC), American College Health Association (ACHA), Washington State Department of Health (WA DOH), and Spokane Regional Health District (SRHD) strongly recommend that all persons over 16 be vaccinated. **Initial ____**

2) I understand that not receiving one of the COVID-19 vaccines may increase risk of infection for myself and others. I understand that Whitworth reserves the right to isolate or quarantine individuals or exclude individuals from campus if they have symptoms of, exposures to, or test positive for COVID-19, or are at increased risk for COVID-19 during an outbreak. **Initial ___**

3) I understand that polymerase chain reaction (PCR), antibody or antigen tests are not sufficient evidence of immunity to COVID-19. **Initial ___**

4) I understand by declining this vaccination, I will be required to follow WA DOH and SRHD guidelines regarding face coverings, physical distancing, testing, quarantine and isolation. **Initial ___**

5) I understand that students who are fully vaccinated and have completed the attestation requirement will not be required to undergo asymptomatic testing provided by Whitworth. **Initial ____**

6) I understand by declining this vaccination, I will be required to participate in COVID-19 testing on a regular basis and that there may be disciplinary consequences for not participating in testing. **Initial____**

7) I understand if an outbreak of COVID-19 occurs on the Whitworth campus, and I have not established my immunity by documented vaccinations, I may be required to leave campus and cease participation in all university activities (including living in residence halls, eating in dining facilities, attending classes, participating in extracurricular activities, participating in University District-located classes, etc.) at my own expense until health officials have determined that the outbreak is controlled. **Initial ___**

8) I understand by declining this vaccination, I will not be able to participate in any study abroad programs outside of the United States. **Initial ___**

9) I understand if I test positive for COVID-19 while studying abroad/studying away, any expenses resulting from isolation/quarantine/travel, including transportation and medical care, will be my own responsibility. **Initial ___**

10) I understand that Whitworth is not obligated to provide remote instruction to me if I am placed in isolation or quarantine. **Initial ___**

11) Furthermore, I understand that Whitworth is not responsible for any of my academic, personal or financial losses in the context of a COVID-19 outbreak on campus. I am solely responsible for any negative impacts on my academic progress, including potential academic failure or withdrawal. In addition, I am aware that if I withdraw or am asked to leave campus for COVID-19-related issues, I am not entitled to a refund of any tuition, fees, or room and meal payments. **Initial ___**

12) If, in the future, I want to be vaccinated for COVID-19, I understand that I can receive the vaccination(s) at that time through a clinic, pharmacy or provider of my choice at my own expense. **Initial ___**

13) I understand that Whitworth reserves the right to request additional documentation. If approved, the exemption will remain in effect for the duration of the current academic year. Requests must be renewed annually. **Initial ___**

Student Signature: _____ Date: _____/_____/_____

Parent Signature (only if under 18): _____ Date: _____/_____/_____