☐ Fall 20_____

☐ Spring 20_____

☐ Summer 20_____

UNIVERSITY of HAWAI'I SYSTEM

Request for Exemption From COVID-19 Vaccination on Medical Grounds

On May 17, 2021, the University of Hawai'i announced that beginning in the fall 2021 semester, the COVID-19 vaccination would be part of the health clearance requirements for students. Please be advised, students who receive an exemption will be required to provide proof of a negative COVID-19 test weekly to be on campus. To submit for an exemption based on Medical Grounds, complete the information below and submit this form to your Home Campus Records Office or Student Health Center.

SECTION A: To be completed by student (and/or legal parent/guardian)

Student's Name: _____ UH ID/Username: _____

Phone: _____ UH Email Address: _____UH Home Campus: _____

By signing below: I understand that by not receiving a vaccination, I may be susceptible to preventable diseases for which the vaccination offers immunization, and hereby release the University of Hawai'i from any and all claims I may have as a result of contracting such diseases.

I further understand that my exempt status will be revoked and I may be excluded from University of Hawai'i campuses, facilities, sponsored events, residence halls and classes pursuant to a mandate and/or order of the University of Hawai'i, and/or a federal, state, or local government authority in the event of a health emergency, and will remain excluded until the mandate or order is lifted or I receive the required vaccination(s).

Finally, I understand and agree that I will be responsible for any financial or academic impact to me that may incur as a result of my exclusion, and I hereby release the University of Hawai'i from any and all claims I may have as a result of the exemption or the exclusion.

Student's Signature _____ Date: _____

Parent/Guardian Name:
[if student is <18 years] _____ Signature: _____

SECTION B: To be completed by Healthcare Professional ONLY (MD, DO, ND, APRN-Rx, PA)A medical exemption from the Covid-19 vaccinations is being requested based upon the following contraindication(s) and/or precaution(s): (Check all that apply to this patient.)

Contraindications:

☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a component of the COVID-19 vaccine

☐ Immediate allergic reaction of any severity to a previous dose or known allergy to a component of the vaccine

Precautions:

☐ History of an immediate allergic reaction to a vaccine or injectable therapy

☐ Moderate to severe acute illness

This exemption begins on: ____/____/____ (Date) and ends on: ____/____/____ (Date)
MONTH DAY YEAR MONTH DAY YEAR

I certify that in my medical judgment, due to the contraindication(s)/precaution(s) noted above, this student is exempt from the specific Covid-19 vaccine(s) named for the period indicated.

_____ _____ _____

Healthcare Professional Name/Title (print) Healthcare Professional Signature Date

Address: _____ License Number: _____

For Office Use Only:

Effective Term _____ Processed By: _____ Processed Date: _____