**Certificate of Exemption—Medical**

For COVID - 19 Immunization Requirements

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| **Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Initial: \_\_\_\_\_\_**  **Birthdate (MM/DD/YYYY): \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **NOTICE:** This form may be used to exempt an employee, student, volunteer or contractor from the requirement of vaccination against  COVID-19. This form must be completed by a healthcare practitioner and signed by individual or guardian requesting exemption. |
| **Medical Exemption**  A health care practitioner may grant a medical exemption to a vaccine required by Washington State executive order 21 - 14 only if in their judgment, the vaccine is not advisable for the individual based on the medical contraindications and precautions for COVID - 19 immunization outlined in the most recent General Recommendations of the Advisory Committee on Immunization Practices (ACIP)/ CDC. Providers can find guidance on medical exemptions by reviewing Advisory Committee on Immunization Practices (ACIP) recommendations via the Centers for Disease Control and Prevention publication, “Guide to Vaccine Contraindications and Precautions,” or the manufacturer’s package insert. The ACIP guide can be found at: www.cdc.gov/vaccines/hcp/acip-recs/ general-recs/contraindications.html or <https://www.cdc.gov/vaccines/covid-19/index.html>  *Please indicate type and reason for exemption by selecting the appropriate box below. If the exemption is temporary please indicate the date the exemption expires.*   |  |  |  |  | | --- | --- | --- | --- | | **Exemption** | **Permanent Exempt** | **Temporary Exempt** | **Expiration Date for Temporary Medical** | | Received monclonal antibodies or convalescent plasma for COVID - 19 treatment in the last 90 days |  |  |  | | History of heparin - induced thromboctopenia within last 90 days |  |  |  | | History of Guillain-Barre Syndrome |  |  |  | | Persons with uncontrolled immunocompromising or autoimmune conditions |  |  |  | | Severe allergic reaction after a previous dose or to a component of the COVID - 19 vaccine |  |  |  | | Known (diagnosed) allergy to a component of the vaccine |  |  |  |   **Health Care Practitioner Declaration**  I affirm that I have reviewed the current CDC/ACIP Contraindications and Precautions and declare based on the contraindication(s)/ precautions(s) checked above the currently available vaccines for COVID -19 are not advisable for this indiividual. I have discussed the benefits and risks of immunizations with the individual as a condition for exempting them. I certify I am a qualified MD, ND, DO, ARNP or PA licensed in Washington State, and the information provided on this form is complete and correct.  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** X**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Licensed Health Care Practitioner Name (print) Licensed Health Care Practitioner Signature Date   MD  ND  DO  ARNP  PA Washington License #**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Personal Declaration**  I have discussed the benefits and risks of immunizations with the health care practitioner granting this medical exemption. The information on this form is complete and correct.  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** X **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Name (print) SignatureDate |