ARUP LABORATORIES

A nonprofit enterprise of the University of Utah and its Department of Pathology

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INSTRUCTIONS AND FAX COVER SHEET

Request form for Medical Exemption from COVID-19 Vaccination

The Medical Exemption Request Form must be completed by a licensed practitioner (includes MD, DO, APRN, or PA). The practitioner is required to validate and sign a medical contraindication (approved contraindications included on the form) that does not allow immunization/vaccination.

- This is a request for exemption only, and will be reviewed by an ARUP medical provider for appropriateness.
- Insufficient information or providing medical conditions that are not approved contraindications or precautions will result in request for further information and/or denial of exemption.

Instructions

Please complete and **fax this form to the ARUP Family Health Clinic at 801-584-5206.**

Please provide your office phone and fax number so that ARUP may contact you with critical results.

Physician name: _____

Office Phone: _____ Ext: _____

Secure Fax Number: _____

For further questions, please contact the ARUP Family Health Clinic Lab at 801-584-5144.

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☐ **REQUEST FORM FOR MEDICAL EXEMPTION (INCLUDES TEMPORARY EXEMPTIONS):**

A licensed independent practitioner (includes MD, DO, APRN, or PA) is required to validate and sign a medical contraindication that does not allow the immunization/vaccination.

To be filled out by provider: In the space below, please answer **ALL** of the questions. Please be as specific and provide as much detail/information as possible. For guidance on medical contraindications, see the CDC/ACIP Contraindications and Precautions at: https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html and specifically for COVID-19 vaccines at: https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html

Exemption or Deferral Request for: ☐ Influenza ☐ MMR ☐ Varicella ☐ Hepatitis B ☐ Td ☐ Tdap ☐ COVID-19

1. Patient Name, DOB _____
2. Specific contraindication or medical condition*: _____

   _____
3. Date of contraindication/reaction/condition*: _____
4. Description of reaction to vaccine or vaccine component* (indicate what vaccine or vaccine component and list of symptoms):_____

   _____
5. Time from vaccination to start of reaction/condition: _____Duration of symptoms of reaction/condition to receiving the vaccine:_____
6. Correlation of reaction/condition to receiving the vaccination*:_____
7. Indicate if there are any of the following specific contraindications for COVID-19 vaccines:
   - ☐ History of previous severe allergic reaction (e.g., anaphylaxis) to the COVID-19 vaccine or component of the vaccine defined as developing hives, swelling of the lips, throat or tongue, difficulty breathing within 4 hours of administration (does not include sore arm, local reaction, or self-limited febrile illness), as detailed above.
     - Specify which vaccine received: ☐ Pfizer ☐ Moderna ☐ Johnson & Johnson ☐ Other:_____
   - ☐ Documented allergy to: ☐Polyethylene glycol (PEG) ☐ Polysorbate
8. If pregnant, due date: _____
   - ☐ If requesting a deferral for COVID-19 vaccine: I acknowledge that COVID-19 vaccination is recommended in pregnancy by the CDC and the American College of Obstetricians and Gynecologists to protect pregnant women (who are at increased risk of severe disease) and to protect the baby after it is born. Nevertheless, after discussing with my patient, the patient requests that they be exempt from this recommended vaccine while pregnant.
9. Other conditions for a time limited medical exemption of a COVID-19 vaccine:
   - ☐ Receipt of COVID-19 monoclonal antibody treatment and 90 days following infusion. Date of infusion: _____
   - ☐ Although persons with recent COVID-19 acute infection are eligible for vaccination, exemptions are allowed for 90 days. Date of 1st positive SARS-CoV-2 test: _____
   - ☐ Diagnosis of Multisystem Inflammatory Syndrome-Adults (MIS-A) with accompanying medical documentation

*Insufficient information or providing medical conditions that are not approved contraindications or precautions will result in request for further information and/or denial ofexemption.

Provider signature: _____ Date: _____

Provider Name (print):_____ Credentials: _____

Practice Location (with city and state): _____ Phone: _____