SUNY Downstate Health Sciences University
Division of Student Affairs

University Hospital of Brooklyn
College of Medicine
School of Graduate Studies
College of Nursing
School of Health Professions
School of Public Health

Medical Exemption to Required COVID Vaccination for SUNY Downstate Students

On August 21, 2021, the State University of New York issued a COVID-19 Vaccination Policy which requires all students on SUNY campuses to be vaccinated for the Fall 2021 semester. In addition, on August 18, 2021, the New York State Commissioner of Health issued an Order, pursuant to Public Health Law Section 16, requiring all patient-facing health care workers in the State of New York to receive their first dose of the vaccine by September 27, 2021. SUNY Downstate Health Sciences University ("SUNY Downstate") has determined, by virtue of the unique, physical structure of SUNY Downstate's academic and healthcare enterprises, that anyone who may encounter a patient at any time is considered a "patient-facing healthcare worker." Therefore, all persons/individuals within the entire campus community—staff, students, faculty (including voluntary), volunteers, and long-term contractors/agency employees – must be vaccinated.

All SUNY Downstate students will be required to provide proof of vaccination to comply with the mandates by the State University of New York and the Commissioner of Health. Only persons who have received a medical or religious exemption will be excused from the mandate. Each request for a medical or religious exemption must be made in writing and should be submitted as soon as possible to meet the compliance deadline. The exemption request must be submitted via the attached forms and will be evaluated as follows:

Medical exemptions:

- May be granted if a licensed physician, physicians' assistant, licensed nurse practitioner, or licensed midwife (caring for a pregnant employee) states in writing that the specific COVID-19 vaccination may be detrimental to the individual's health or is otherwise medically contraindicated.
- Must include a statement indicating why the COVID-19 vaccine may be detrimental, including a detailed explanation of the valid medical basis for such determination, and the length of time for which it may be detrimental.
- Should be based on the most up-to-date medical guidelines regarding the COVID-19 vaccine and its contraindications.
- May be granted on a temporary basis up to the point when the condition supporting an exemption is expected to resolve or expire. If related to a permanent condition, the exemption may remain in place during the period of your matriculation at SUNY Downstate.

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SUNY Downstate reserves the right to request additional information which it deems necessary to properly evaluate any exemption request. A student's failure to provide or authorize the release of requested additional information will result in a denial of the exemption. Submission of false information in connection with the request for an exemption will subject the student to appropriate disciplinary action.

Decisions regarding exemption requests will be communicated to the individual via their SUNY Downstate/campus-based email.

If an exemption is granted, the student may be required to comply with additional safety protocols, including ongoing testing requirements, and/or temporary exclusion from certain facilities or activities to protect the health and safety of the campus community in accordance with public health guidelines and SUNY Downstate's policies.

Note: Students who also are employees of SUNY Downstate must file an exemption request as an employee. The decision on the employee side will be honored in your status as a student.

Forms can be returned to the Office of Student Affairs via email (studentaffairs@downstate.edu), via fax (718-270-7592) or in person to the Student Services Center (Basic Science Building 1-1012).

SUNY DOWNSTATE Health Sciences University

COVID-19 Vaccination Medical Exemption Request Form

To request a medical exemption from the SUNY COVID-19 Vaccination requirement, please complete this form and submit it to the Office of Student Affairs. A decision regarding your request will be released through your Downstate email.

Student Name: _____

Student ID Number: _____

School (check one): ( ) Medicine ( ) Public Health ( ) Nursing
( ) Health Professions ( ) Graduate Studies

Academic Program/Class Year: _____

SUNY Downstate/Campus Based Email: _____

Phone: _____

Please check each box to acknowledge:

☐ While my request is pending, I understand that I must comply with the campus' COVID-19 related health and safety protocols (e.g., masks/face coverings, social distancing, regular surveillance testing) applicable to unvaccinated or partially vaccinated individuals as a condition of my physical presence in a SUNY Facility.

☐ I certify that I have confirmed with my academic program that not receiving the COVID-19 Vaccination will not prevent the completion of my programmatic or curricular requirements.

☐ If my request is granted, I understand that I will be required to comply with the campus' COVID-19 related health and safety protocols (e.g., mask/face coverings, social distancing, regular surveillance testing) if accessing a SUNY Facility as a condition of my on-going physical presence. I am aware that should a COVID-19 outbreak occur at the campus that I may be excluded from all in-person classes and activities, and that if I am enrolled in courses that require a physical presence on campus that I may not be able to complete my academic coursework remotely. I acknowledge that any refund I might be entitled to in the case of a COVID-19 outbreak would be subject to all existing SUNY policies.

☐ I certify that my statements above, and all supporting documentation, are true and accurate, and that the receipt of the COVID-19 vaccination may be detrimental to my health.

A medical exemption may be granted upon receipt of a completed form (below) signed and certified by a licensed physician, physicians' assistant, or nurse practitioner, who is not related to the student, and whose specialty is appropriate to the associated condition. Medical exemptions expire when the medical condition(s) contraindicating COVID-19 immunization changes in a manner which permits immunization, as determined by SUNY Downstate in reviewing each individual's request.

Student Signature: _____ Date: _____

Please note that the campus reserves the right to request additional documentation to support a request for a medical exemption.

State University of New York Downstate Health Sciences University
450 Clarkson Avenue, MSC 85, Brooklyn, NY 11203-2098 • Phone 718 270-2187 Fax 718 270-7592 • studentaffairs@downstate.edu

Part II. Medical Exemption Request (to be completed by medical provider)

A licensed medical provider (Physician, Physician's Assistant, or Nurse Practitioner) and student should review the CDC guidance regarding contraindications for COVID-19 vaccines. The provider must complete Section(s) A and/or B and provide their provider information in Section C.

The above-named individual is requesting a medical exemption from SUNY's COVID-19 vaccination requirement. A medical exemption may be allowed for certain recognized contraindications.

Section A. Medical Provider Certification of Contraindication: I certify that my patient (named above) cannot be vaccinated against COVID-19 because of the following contraindication:

Please select which of the medically indicated COVID-19 vaccine contraindications defined by the CDC apply:

☐ Severe allergic reaction (anaphylaxis) after a previous dose or to a component of the COVID-19 Vaccine, including Polyethylene Glycol (PEG). (***Describe reaction/response below and contraindication to alternative vaccines***.)

☐ Immediate allergic reaction to previous dose or known (diagnosed) allergy to a component of the vaccine. (***Describe reaction/response below and contraindication to alternative vaccines***).

Additional details on the selected option(s) above (to be completed by the medical provider):

_____

_____

_____

_____

Please note that **NONE of the following are considered contraindications** to the COVID-19 vaccine.

- Local injection site reactions to previous COVID-19 vaccines (erythema, induration, pruritus, pain).
- Expected systemic vaccine side effects in previous COVID-19 vaccines (fever, chills, fatigue, headache, lymphedema, diarrhea, myalgia, arthralgia.
- Previous COVID-19 infection.
- Vasovagal reaction after receiving a dose of any vaccination.
- Being an immunocompromised individual or receiving immunosuppressive medications.
- Autoimmune conditions, including Guillain-Barre Syndrome.
- Allergic reactions to anything not contained in the COVID-19 vaccine, including injectable therapies, food, pets, oral medications, latex etc. (Please note the COVID vaccine does not contain egg or gelatin.)
- Alpha-gal Syndrome.
- Pregnancy, undergoing fertility treatment, intention to become pregnant or breast-feeding. (Please note the American College of Obstetricians and Gynecologists, the Society for Maternal-Fetal Medicine and the Society for Reproductive Medicine all strongly recommend COVID-19 vaccination during pregnancy.)
- The medical condition of a family member or other residing in the same household as the student.

Clinician Certification: **By completing this form, you certify that different methods of vaccinating against COVID-19 have been fully considered and that the patient has the contraindication indicated above that precludes any/all available vaccinations for COVID-19.** Information about approved medical exemptions for COVID-19 vaccination can be reviewed at https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html

Section B. Medical Provider Certification of Disability That Makes COVID-19 Vaccination Inadvisable

"Disability" is defined as any impairment resulting from anatomical, physiological, genetic, or neurological conditions which prevents the exercise of a normal bodily function or is demonstrable by medically accepted clinical or laboratory diagnostic techniques and any other condition recognized as a disability under applicable law.

"Disability" may include pregnancy, childbirth, or a related medical condition where reasonable accommodation is medically advisable.

I certify that my patient (named above) has the following disability that makes COVID-19 Vaccination inadvisable:

_____

Additional details on why the disability listed above makes COVID-19 Vaccination Inadvisable (to be completed by the medical provider):

_____

_____

_____

_____

_____

The patient's disability is: ☐ Permanent
☐ Temporary

If temporary, the expected end date is: _____

Section C. Medical Provider Information

Provider Name: _____

Provider National Provider Identifier (NPI): _____

Provider Specialty: _____

Provider Employer/Affiliation: _____

Provider Phone: _____

Provider Signature: _____ Date of signature: _____