

University of Notre Dame Vaccine Exemption Request Form

Enter info and upload at Online Patient Portal – go to: nd.studenthealthportal.com
Choose 'Immunization Exemption Request Form' from the Document Upload tab on the portal

Last name: _____ First name: _____ Date of birth: ___/___/___ ND ID #: _____

SECTION IN BOX BELOW TO BE COMPLETED BY PROVIDER FOR MEDICAL EXEMPTION REQUESTS

Medical Exemption

A written statement by a licensed, treating medical provider [a physician (MD or DO), Nurse Practitioner (NP) or Physician's Assistant (PA)], that includes an explanation and documentation as to why at least one of the following criteria apply to their patient for any vaccine(s) for which an exemption is requested.

A. For COVID-19 vaccine exemption:

Applicable [CDC contraindication](#) for the vaccine(s) which include a documented anaphylactic allergic reaction or other severe adverse reaction to any COVID-19 vaccine--e.g., cardiovascular changes, respiratory distress or history of treatment with epinephrine or emergency medical attention to control symptoms. Generally, does not include gastro-intestinal symptoms as the sole presentation of allergy.

B. For all other vaccine exemptions, please identify specific vaccine(s): _____

Applicable contraindication found in the manufacturer's packaging insert for the vaccine(s), or a statement that the physical condition of the person or medical circumstances relating to the person is such that immunization is not considered safe.

FOR ALL EXEMPTION REQUESTS:

Please indicate the specific nature of the *medical condition or circumstances* that contraindicate immunization with the vaccine(s):

Permanent Exemption

Temporary Exemption until ___/___/___

Health Provider signature: _____

Date: _____

Signing provider verifies accuracy of above info

Health provider printed name: _____

Clinic Address: _____

Phone: _____

