Required COVID-19 Vaccination Program

College of Southern Maryland
La Plata · Leonardtown · Prince Frederick · Regional Hughesville

Healthcare Provider Certification Form

Name:_____Phone: _____

Address: _____

I_____give permission for my healthcare provider to complete this form and provide the requested information concerning my medical condition that prevents me from receiving a COVID-19 vaccination to the College of Southern Maryland.

Patient signature:_____ Date: _____

Dear primary healthcare provider,

The College of Southern Maryland requires all employees and students to be fully vaccinated against COVID-19, with the exception of individuals with approved exemptions. Your patient is requesting anexemption based on their medical contraindications. For the College of Southern Maryland to review the request, we require the following medical information from you.

Please indicate the reason(s) all three of the available COVID-19 vaccinations are medically contraindicated.

Option One—Allergy

☐ A known history of a severe allergic reaction (i.e. anaphylaxis) to any component of the COVID-19 vaccine or to a substance that is known to be cross-reactive with a component. PEG (polyethylene glycol) is in both Moderna and Pfizer; Polysorbate is in J&J, and these are not cross-reactive.

Please indicate which of the following vaccines are contraindicated and name the components, by vaccine. Note: None of the available U.S. vaccines contain egg or egg products. History of egg allergy will not be accepted as a routine medical exemption. Contraindications must exist for all available vaccines to achieve exemption.

- Moderna—list the component(s): _____
- Pfizer—list the component(s): _____
- Janssen/J&J—list the component(s): _____

☐ A documented history of a severe allergic reaction/anaphylaxis after a previous dose of the COVID-19 vaccine. Please indicate which vaccine the patient had a reaction to, the date of the vaccine and reaction, as well as whether this experience indicates a contraindication to each of the other alternative vaccines listed.

- Moderna—date of vaccine and reaction: _____
- Pfizer— date of vaccine and reaction: _____
- Janssen/J&J— date of vaccine and reaction: _____

Option Two—Physical condition/medical circumstance

☐ The physical condition of the patient or medical circumstances relating to the individual are such that immunization is not considered safe. Please state, with sufficient detail for independent medical review, the specific nature and probable duration of the medical condition or circumstances that contraindicate immunization with the COVID-19 vaccine. **This justification must be evidence-based or adhere to another peer-review standard.**

Explanation:

_____

_____

_____

_____

Option Three—Other

☐ Other. Please provide this information in a separate narrative (attached) that describes, in detail, the physical or medical condition or disability in detail that you opine would exempt this individual from vaccination. **The justification must be defensible with peer-review standard, and citations to strengthen the evidence are encouraged.**

Explanation:

_____

_____

_____

Deferrals

☐ Receipt of COVID-19 monoclonal antibody treatment (90-day deferral).

Date of infusion: _____

☐ Recent COVID-19 (test positive) acute infection with current fever (deferral until fever resolves).

Date of first positive test: _____

Date of most recent fever/symptoms: _____

☐ Other physical or medical condition which is considered temporary or anticipated to be resolved in a defined time period. _____

☐ Receipt of high titer COVID-19 convalescent plasma within the past 90 days.

Date of infusion: _____

Certification

I certify that _____ (patient name) has the above contraindication and support the request for a medical exemption from the COVID-19 vaccine requirement.

Provider's name (please print): _____ Specialty: _____

Provider's license number: _____

Signature: _____ Phone: _____

Address: _____

Please return completed form to patient.