COVID-19 Vaccination Requirement  
Student Medical Exemption Request Form

Student Name: ____________________________ Student ID #: ____________________________

School:___________________________________ Anticipated Graduation Year: ____________________________

Please write your initials in the space next to “Acknowledged” to confirm that you have read and understand that statement.

Emory University requires COVID-19 vaccination of our students to prevent COVID-19 and its complications, including death. Acknowledged ________.

By interacting with others in person, I could transmit COVID-19 at work to students, co-workers, and outside of work to my family and/or friends, even if I have no symptoms. Acknowledged ________.

I have received education about the effectiveness of COVID-19 vaccines, as well as possible side effects. Acknowledged ________.

I understand that I cannot get COVID-19 from the COVID-19 vaccine. Acknowledged ________.

I acknowledge my responsibility to only request a medical exemption if truly necessary. Acknowledged ________.

Even though I can receive the COVID-19 vaccine at no charge, I want a medical exemption from taking the COVID-19 vaccine. Acknowledged ________

In your student role, do you provide direct patient care? (Please select a response): Yes_______No_____

Has Emory University Student Health Services granted you an exemption from any other mandatory vaccine requirement in the past? Yes_______No________________

List Exemption Reason:

_____ I have severe, life-threatening allergies to the COVID-19 vaccine or an ingredient in the vaccine.

_____ I have had a severe, life-threatening prior reaction to the COVID-19 vaccine.

_____ I have a current medical condition that prohibits me from obtaining the COVID-19 vaccine.

Please describe that condition below:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
A signature from a licensed healthcare provider below or on an attached document is required to validate a medical contraindication that does not allow you to get the COVID-19 vaccine.

Physician Signature/Date:

Physician Name (Please Print):

Physician Contact Phone Number: ______________________________

To be considered for a medical exemption, you must provide documentation from a licensed healthcare provider supporting your request. This should include medical records with the reaction or other medical reason for the exemption. Please submit your documentation with this completed form. Requests will not be considered without documentation.

I understand that my request may not be granted if it is unreasonable, creates undue risk to university safety or if it creates an undue hardship on your school. Acknowledged __________

Date: ___________________________ Student ID #: ___________________________

Print Name: ______________________ Signature: ____________________________

Please visit the Student Health Patient Portal to upload this form and submit your request. Please allow 3-5 business for review. You will receive confirmation of receipt and the decision regarding your submission through the portal via secure message.