AUCC Student Health and Wellness Center

Student ID #: _____
Name: _____

Medical Exemption / Accommodation Request for Vaccination Requirements

**** NOTE ****

In order to ensure a prompt review of your request, this form must be completed, accompanied by the appropriate documentation identified below, and submitted to the AUCC Student Health and Wellness Center **at the same time**. Failure to submit this form, together with the other required documentation, may result in a delayed evaluation of your request and impede the University's ability to timely provide the requested exemption and accommodation.

The Atlanta University Center Consortium Student Health and Wellness Center (AUCC-SHWC) is committed to providing equal healthcare and educational opportunities and an educational environment that is free of unlawful harassment, discrimination, and retaliation. As such, AUCC- SHWC is committed to complying with all laws protecting individuals with disabilities or medical conditions. When requested, AUCC-SHWC will provide an exemption/reasonable accommodation for any known medical condition or disability of a qualified individual which prevents the student from receiving the selected vaccine, **provided the requested accommodation is reasonable and does not create an undue hardship for your AUCC institution or pose a direct threat to the health and/or safety of others in the workplace, educational environment, residence halls (if applicable) and/or to the requesting student**.

To request a Medical Exemption/Accommodation related to your AUCC institution's vaccination requirement, please complete Part 1 of this form, have your healthcare provider complete Part 2 (the certification portion), and return them to AUCC-SHWC via Point and Click (PNC) Patient Portal under the Downloadable Forms Tab. This information will be used by AUCC-SHWC, The Office of Compliance, Disability Services, or other appropriate personnel to engage in an iterative process to determine eligibility for such exemption/accommodation and if applicable, to determine the reasonable accommodations which can be provided to enable the student to have an equal opportunity to participate in the education program without posing a threat of harm to self or others. If a student refuses to provide such information, such a refusal may impact the AUCC-SHWC's ability to adequately understand the individual's request or to effectively engage in the interactive process to identify possible accommodations.

Medical exemptions/accommodations for vaccines will be considered if the student provides a written certification by a licensed, treating medical provider [i.e. a physician (MD or DO), nurse practitioner (NP), or physician's assistant (PA)] of one of the following:

1. The applicable CDC contraindication for the vaccine, or
2. The applicable contraindication found in the manufacturer's package insert for the vaccine; or
3. A statement that the physical condition of the person or medical circumstances relating to the person are such that vaccination is not considered safe, indicating the specific nature and probable duration of the medical condition or circumstances that contraindicate immunization with the vaccine.

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PART 1A – TO BE COMPLETED BY THE STUDENT (OR PARENT/GUARDIAN IF STUDENT IS UNDER 18 YEARS OF AGE):

NAME: _____ **DATE OF BIRTH:** _____

STUDENT ID#: _____ **DATE OF REQUEST:** _____

CIRCLE YOUR SCHOOL: Morehouse School of Medicine / Clark Atlanta University / Morehouse College

SCHOOL EMAIL ADDRESS: _____ **PHONE #:** _____

VACCINE EXEMPTING Please Initial by the vaccine(s) you are requesting an exemption:

INITIALS	VACCINE	INITIALS	VACCINE
	Tetanus Diphtheria Pertussis (Tdap or Td)		Measles, Mumps, Rubella (MMR)
	Meningitis Conjugate or Men ACWY		Meningococcal B
	Varicella		Hepatitis B
	COVID-19		Influenza

Initials	**Verification of Accuracy:** The undersigned verifies that the information submitted in support of this request for an accommodation is complete and accurate to the best of his or her knowledge, and the undersigned understands that any intentional misrepresentation contained in this request may result in disciplinary action. The undersigned also understands that this request for an accommodation may not be granted if it is not reasonable, if it poses a direct threat to the health and/or safety of others, school environment, housing facilities and/or to me), or if it creates an undue hardship on the AUCC institution.
Initials	**Medical Release:** The undersigned hereby authorizes my medical provider (or my student's medical provider, if the student is under the age of 18) to release my (or my student's) medical information to AUCC-SHWC for the purpose of engaging in the interactive process to determine the availability of reasonable accommodations in response to my vaccine exemption request. I understand that I may revoke this authorization in writing at any time, except to the extent that the AUCC-SHWC has acted in reliance of this authorization, and if I revoke this authorization, such revocation will not have any effect on disclosures made prior to such revocation. I have had the opportunity to read and consider the contents of this authorization. I confirm that the contents are consistent with my direction. A photocopy of this form shall have the same legal validity as the original.

Signature (Student, if 18 years of age or older): _____

Required if Student is Under the Age of 18: Parent/Legal Guardian's Name (Print): _____

Parent/Legal Guardian's Signature: _____

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AUCC Student Health and Wellness Center

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PART 1B- TO BE COMPLETED BY STUDENT ONLY REQUIRED IF YOU ARE REQUESTING EXEMPTION FROM MENINGOCOCCAL VACCINES

If you are requesting an exemption from the Meningococcal Conjugate/Men ACWY or Meningitis B vaccines you must acknowledge the following statement:

I understand that meningococcal disease is a contagious but largely vaccine preventable infection of the spinal cord fluid and fluid around the brain. I understand that all college students living in residence halls, particularly freshmen, are at a moderately increased risk of contracting meningococcal disease. I understand that meningococcal disease is a serious disease that can lead to death within only a few hours of onset, that 1 in 10 cases is fatal and that 1 in 7 survivors of the disease is left with a severe disability such as loss of limb, mental retardation, paralysis, deafness or seizures. The CDC, the American College Health Association and AUCC-SHWC strongly recommend that students receive one dose after age 16 of Men ACWY and 2 doses of Meningococcal B vaccine after age 16. While the AUCC-SHWC requires Meningococcal ACWY and Meningococcal B vaccines, I understand that two types of meningococcal vaccinations exist (Meningococcal ACWY and Meningococcal B) which will decrease but not totally eliminate, the risk of contracting meningococcal disease. However, I want to request a medical exemption for Men ACWY and Meningococcal B immunization. I understand that by requesting an exemption for these immunizations, I may continue to be at risk of acquiring this disease. I also acknowledge that I could spread Meningitis to vulnerable students, others in the clinic waiting area, or to university staff. I understand that if an outbreak of Meningitis were to occur on the AUCC-SHWC campus, I would be removed from all campus activities (including residence facilities and classes) until health officials determined that the outbreak was controlled. If, in the future, I want to be immunized with Men ACWY or Meningococcal B vaccines, I understand that I can receive it at AUCC-SHWC on a fee-for-service basis.

I acknowledge my responsibility to request a medical exemption to this vaccine requirement only if necessary and based in a valid medical contraindication to being vaccinated.

Student/Parent/Guardian Signature: _____ Date: ____ /____ /____

AUCC Student Health and Wellness Center

Student ID #: _____
Name: _____

PART 2 – TO BE COMPLETED BY THE STUDENT MEDICAL PROVIDER

NAME: _____ DATE OF BIRTH: _____

ATTN: Medical Provider

Your AUCC institution requires all students to receive vaccines prior to arrival on campus. The above-named individual is requesting an exemption from the vaccines indicated in Part 1 on the basis of a medical contraindication to receiving the vaccine(s). A medical exemption from vaccines may be allowed for certain recognized contraindications.

Please complete the form below.

Should you have any questions, please contact Student Health and Wellness at 404-756-1241.

The above person should not be immunized for the following reasons (Please check all that apply.):

_____	History of previous allergic reaction to indicate an immediate hypersensitivity reaction to a component of the vaccine.
_____	The physical condition of the person or medical circumstances relating to the person are such that immunization is not considered safe. Please indicate the specific nature and probable duration of the medical condition or circumstances that contraindicate immunization with the vaccine.
_____	Other – Please provide this information in a separate narrative that describes the exemption in detail.

I, the undersigned, do hereby certify that _____ (Print Name of Student) has the above contraindication, and I request a medical exemption from the selected vaccination(s).

Medical Provider Signature: _____

Print Name: _____

Date: _____

Office Address: _____

Phone Number: _____

Office Stamp: REQUIRED

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