Felician UNIVERSITY
THE FRANCISCAN UNIVERSITY OF NEW JERSEY

STUDENT INTERACTIVE PROCESS QUESTIONNAIRE

COVID–19 VACCINE EXEMPTION (Medical)
08/06/2021

To: _____

Date Needed: _____

Felician is committed to complying with all laws protecting individuals with disabilities or medical conditions.

To request an Exemption/Accommodation related to Felician's COVID-19 vaccination policy, please complete **Part 1** of this form, have your healthcare provider complete **Part 2** (the Certification portion), and return them to VaccineRequest@felician.edu. This information will be used by Felician University or other appropriate personnel to engage in an interactive process to determine whether you are eligible for such exemption.

Medical exemptions for the COVID-19 vaccine will be considered if the student provides a written certification from a physician licensed to practice medicine indicating that an immunization is medically contraindicated for a specific period of time, and setting forth the reason(s) for the medical contraindication, based upon valid medical reasons as enumerated by the 2007 Advisory Committee on Immunization Practices (ACIP), Recommended Child, Adolescent, and Adult Immunization Schedules and the ACIP Recommendations.

Part 1 – To Be Completed by Student (or parent of minor student):

Name: _____

Date of Request: _____

Review

I understand that as a student, my vaccination records are reviewed annually. If an exemption is granted and my medical condition changes to allow vaccination in the future, I understand that this exemption may be terminated.

Signature:_____

Date: _____

Print Name: _____

Attendance

I understand that I may be temporarily excluded from classes, programs, extracurricular activities, or other campus events in the event during a vaccine-preventable disease outbreak or threatened outbreak.

Signature:_____

Date: _____

Print Name: _____

Adherence to Felician Policies

Should I contract a communicable or contagious disease, I will immediately report it to Health Services at Felician University and comply with the isolation and quarantine procedures specified by the University and remove myself from the University community if so advised.

I also understand and agree to comply with and abide by all Health Services and University policies and procedures. This may include requirements relating to the prevention of the spread of COVID-19, including maintaining social distance and wearing a mask while on campus.

Signature:_____

Date: _____

Print Name: _____

Verification and Accuracy

I verify that the information I am submitting in support of my request for an accommodation is complete and accurate to the best of my knowledge, and I understand that any intentional misrepresentation contained in this request may result in disciplinary action.

Signature:_____

Date: _____

Print Name: _____

Part 2 – To be completed by Student's Medical Provider:

Student's Name: _____

Attention Medical Provider:

Felician requires a COVID-19 vaccination as a condition of enrollment. The abovenamed student is requesting an exemption from this vaccination requirement. A medical exemption from the COVID-19 vaccination may be allowed for certain recognized contraindications.

IMPORTANT NOTE TO HEALTHCARE PROVIDER:

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. **To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information.** "Genetic information" as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Please complete the form below. Thank you.

The above person should not be immunized for COVID-19 for the following reasons:

_____
_____
_____
_____

Please indicate the specific nature and probable duration of the medical condition or circumstances that contraindicate immunization with the COVID-19 vaccine.

_____
_____
_____
_____

I certify that _____ has the above contraindication and request a medical exemption from the COVID-19 vaccination.

Medical Provider Signature: _____

Date: _____

Print Name: _____

Address:_____

_____

Phone number: _____

AFFIX STAMP BELOW:

Part 3 – To be completed by [HEALTH SERVICES]

Date this Request Form Received in [**HEALTH SERVICES**]: _____

Interactive Discussion Date(s) if applicable:

_____
_____
_____

Exemption/Accommodation granted? _____Yes _____ No

Describe Exemption/Accommodation:

_____
_____
_____

If Exemption/Accommodation granted, list required alternative safety precautions required: If Exemption/Accommodation not granted, explain why:

_____
_____
_____

Name of **HEALTH SERVICES** Representative: _____

Signature of **HEALTH SERVICES** Representative: _____

Date: _____