



## Medical Exemption from Vaccine Form

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Please select the vaccination included in the exemption:

- COVID -19
- Influenza (Flu)
- Other (please list) \_\_\_\_\_

If you have an allergy to the above-selected vaccine or a specific medical condition that prevents you from receiving the vaccine and you seek a medical exemption from The GreenMount School's vaccination requirement, you and your physician must complete this form and return it to the Head of School.

While The GreenMount School will carefully review all requests for medical exemptions, approval is not guaranteed. The School will carefully consider each request on a case-by-case basis. You will be notified, in writing, if an exemption has been granted or denied. If the approved exemption contains an expiration, you will be expected to complete the requirement at that time. Should the condition continue, or a new vaccination contraindication occur, a new request with updated documentation is required. Individuals whose requests have been denied are permitted to reapply if new documentation and information should become available.

If approved, any exemption is only valid while The GreenMount School's current vaccination policy is in effect. Moreover, approval of an exemption, if any, is provisionally based on the current vaccination policy and is subject to change based on the school's requirements moving forward.

Adults or students with an approved exemption may be required to comply with additional testing and other preventive requirements as specified in the exemption approval and may be subsequently updated at the school's discretion.

*(continue to next page)*



**ADULT OR STUDENT TO COMPLETE:**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name:

I verify that the information on this form 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, which may include termination. I also understand that my request for an exemption may not be granted if it is not reasonable or if it creates an undue hardship for The GreenMount School. Furthermore, I understand and assume the risks of non-vaccination.

**PHYSICIAN TO COMPLETE:**

The GreenMount School requests that the treating physician of the above-named adult or student provide information to enable the school to assess the applicant's request for a medical exemption from the above-selected vaccine. Please certify below the medical reason that your patient should not be vaccinated by completing Part A and/or Part B, as applicable, Part C.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring the genetic information of employees or their family members. In order 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.

Physician's Name: \_\_\_\_\_

Physician's Specialty/Practice Area: \_\_\_\_\_

Telephone number: \_\_\_\_\_

Address: \_\_\_\_\_

Email: \_\_\_\_\_

*(continue to next page)*



**Part A - Allergy**

A documented history of a severe allergic reaction to any component of the vaccine or to a substance that is cross-reactive with a component. Please indicate which of the following vaccines are contraindicated and name the components to which adult or student is allergic, by vaccine. NOTE: since egg-free vaccine is available, a history of egg allergy will not be accepted as a routine medical exemption.

List the component(s):

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What was the reaction?

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A documented history of a severe allergic reaction after a previous dose of the vaccine is required. Please indicate to which vaccine the Individual had a reaction and the date of the vaccine and reaction.

Date of Vaccine & Reaction:

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**Part B – Physical Condition/Medical Circumstance**

The physical condition or medical circumstances relating to the adult or student is such that vaccination 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 vaccination of the above-selected vaccine:

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*(continue to next page)*



**[OPTIONAL AND SUBJECT TO REVISION ON CASE BY CASE BASIS] Part C –  
Other Considerations**

For COVID -19

Any adult or student who receives a medical exemption may be required to use additional personal protective equipment (e.g., 5 layer mask) and might need to undergo testing on a weekly or another regular basis. If there are any additional measures that you would deem to be equally effective to a vaccine, please identify them and explain the medical basis.

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**Certification**

I certify that (patient name) \_\_\_\_\_ has the above  
contraindication and support the request for a medical exemption from the vaccine requirement.

**Dated:** \_\_\_\_\_

\_\_\_\_\_  
**Physician's Signature**