



Request for Exemption for COVID-19 (SARS-CoV-2) Vaccination

Student's Name _____ ID# _____ Date of Birth _____

UNIVERSITY OF THE PACIFIC requires all students to be fully vaccinated against COVID-19 before they resume in-person campus attendance. These vaccinations are free of charge to the student. Use this form to request an accommodation or exemption from this requirement for medical reasons or due to a sincerely held religious belief, practice or observance.

Information about COVID-19

COVID-19 is a respiratory illness caused by a newly discovered coronavirus that typically causes mild to moderate illness, like the common cold, but can lead to dangerous complications. COVID-19 is a very contagious virus and new variants are continuing to emerge. The COVID-19 vaccines available in the United States have been carefully evaluated in clinical trials and have been authorized by the Federal Drug Administration for emergency use because they make it substantially less likely an individual will contract COVID-19 and become seriously ill. COVID-19 vaccines have been found to be safe and effective. For more information, please review: <https://www.cdc.gov/coronavirus/2019-ncov/vaccines/safety/safety-of-vaccines.html>, or talk to your doctor.

When you are vaccinated against COVID-19, you don't just protect yourself—you protect your friends, family members, coworkers, and everyone in the community—especially those who are at increased risk for severe illness from COVID-19 or are medically unable to receive the vaccines themselves. More studies are ongoing to determine the vaccines' ability to keep people from spreading the virus that causes COVID-19 and how long the vaccines continue to protect from serious illness.

If you wish to request an accommodation or exemption from Pacific's vaccination requirement, please indicate your reason below:

- Medical (Please refer to the Medical Exemption Certification on Page 2 – this must be completed by a licensed medical provider to complete your vaccination exemption)
- Sincerely held religious belief, practice or observance

Acknowledgment and Signature

I have read the above information about COVID-19 vaccination. I understand that by declining this vaccine I continue to be at risk of acquiring COVID-19, which is a serious disease. I may be excluded from certain events or activities depending on health guidance or other requirements. I will follow university standards which may require wearing additional personal protective equipment while on campus, and I may be subject to continuing COVID-19 testing. If clinical, education or external fieldwork is part of my academic program, I understand that sites that allow unvaccinated individuals may not be available and without completing the clinical or fieldwork placements I may be delayed or prevented from timely completing my academic program or licensure requirements.

I understand that the university may change its vaccination policy in the future and require additional measures for those who are not vaccinated. I agree that if at any future point while attending Pacific I decide to receive the COVID-19 vaccine, I will provide proof of vaccination and then this exemption will be considered revoked.

I verify that I am 18 years of age or older, that I understand this Request for Exemption Form and have had the opportunity to ask questions about it.

Student Signature: _____ Date: _____

Parent or Legal Guardian Signature*: _____

*Needed only if student is under 18 years of age



Student's Name _____ ID# _____ Date of Birth _____

MEDICAL EXEMPTION CERTIFICATION

Instructions: Please complete this form to release information regarding your request for an accommodation exempting you from receiving the COVID-19 vaccine due to your health condition.

I have provided this certificate, signed and dated by my licensed health care provider, certifying that I receiving the COVID-19 vaccine is contraindicated due to applicable CDC contraindications and/or my medical condition. I consent to allow University of the Pacific representatives to contact my health care professional(s) to obtain copies of medical records related to my condition, and to consult with the health care professional(s) regarding my condition, only as it relates to my ability to receive the above vaccine.

Student Signature: _____ Date: _____

Parent or Legal Guardian Signature*: _____

*Needed only if student is under 18 years of age

(TO BE COMPLETED BY A LICENCED MEDICAL PROVIDER):

I, _____ [Name of licensed MD, DO, PA, NP] certify that the above-named student is under my medical care and has a medical condition that contraindicates his/her vaccination with the COVID-19 Vaccine at this time. This contraindication is based on (choose one):

- The applicable CDC contraindication(s) to this vaccine
- The physical condition of the person or medical circumstances relating to the person are such that immunization is not considered safe

This contraindication is: Permanent or Temporary

Other recommended accommodations (if any): _____ Other recommended accommodations related (if any): _____

If temporary: the expiration date of the exemption for this vaccine is _____

Health Care Provider Signature: _____ Date: _____

License Number: _____

Health Care Provider Contact Info: _____
[address]

Telephone / Fax: _____