MAINE MARITIME ACADEMY

A College of Engineering, Management, Science, and Transportation

Student Request for Medical Exemption from COVID-19 Vaccination Form

Name: ____

Student ID: _____________________MMA Email: ______________________Phone: __________________

Maine Maritime Academy policy requires that all students are fully vaccinated against COVID-19 vaccination by October 1, 2021, as communicated via this web page: https://mainemaritime.edu/fall-2021/. A medical exemption may be granted upon receipt of a completed form (below), signed and certified by a licensed healthcare provider, who is not related to the submitter, and whose specialty is appropriate to the associated condition.

Any student granted an exemption will be required to take weekly COVID tests and to wear a mask indoors. Individuals with an approved exemption may also be required to take other preventive requirements as specified in the exemption approval, and as may be outlined by later notification and/or posting of requirements on the MMA Fall 2021 COVID information webpage.

In the event of a COVID outbreak on or near campus, individuals holding exemptions may be excluded from all campus facilities and activities, for their protection, until the outbreak is declared to be over.

The Office of Health Services will review all exemption requests, and approval is not guaranteed. After a request has been reviewed and processed, students will be notified via their MMA email address if an exemption has been granted.

Decisions are final and not subject to appeal. Individuals are permitted to reapply if new documentation and information should become available.

In order to submit a request, please:

● Read the CDC COVID-19 Vaccine Information at https://www.cdc.gov/coronavirus/2019-ncov/vaccines/keythingstoknow.html
● Complete this form
● Have your licensed physician, nurse practitioner or physician assistant complete the provider section of this form
● Submit the completed documents to the Health Services office in Curtis or via fax at 207-326-2129

Note: Incomplete submissions will not be reviewed.

● Initial each of the following statements:

	I understand and assume the risks of non-vaccination.
	I understand and agree to comply with and abide by all Maine Maritime Academy COVID-19 policies and procedures.
	I understand that in the event of an outbreak or threatened outbreak, I may be temporarily excluded from MMA facilities and sponsored activities.
	Should I contract COVID-19, I will immediately report it to the College (via email to healthservices@mma.edu) and quarantine myself and await further instructions.
	I acknowledge that I have read the CDC COVID-19 Vaccine Information. I understand that this exemption will expire when the medical condition(s) contraindicating vaccination changes in a manner which permits vaccination.
	I understand that as I am not vaccinated, in order to protect my own health and the health of the community, I will comply with additional COVID-19 testing requirements and other preventive guidance issued by MMA.
	I authorize my licensed health care provider to provide MMA with medical information about my medical exemption for the COVID-19 vaccination.
	I certify that the information I have provided on and in connection with this request is accurate and complete as of the date of this submission.
	I understand this exemption may be revoked and I may be subject to disciplinary action if any false information has been used to request an exemption.

Printed Name: ____
Signature: ____
Student ID: ____________________________ MMA Email: _________________________________
Phone Number: ____

☐ By checking this box and typing my name above, I understand and agree that I am submitting this document electronically and that it is the legal equivalent of having placed my handwritten signature on the submitted document.

Date: ______________________________

Attention Health Care Provider:
Maine Maritime Academy requires that all students receive a COVID-19 vaccination and be fully vaccinated by October 1st . _________________________ (insert patient's name) is requesting a medical exemption from this vaccination requirement. A medical exemption may be allowed for certain recognized contraindications.

Please certify below the medical reason that your patient should not be immunized for COVID-19 by completing this form and attaching available supporting documentation. Information provided on this form will be reviewed by a confidential committee in consideration of the exemption request.

Option 1 - Allergy

__ A documented history of a severe allergic reaction to any component of a COVID-19 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, by vaccine NOTE: since egg-free vaccine is available, history of egg allergy will not be accepted as a routine medical exemption.

- Moderna - List the component(s): ____
- Pfizer - List the component(s): ____
- Janssen/Johnson&Johnson - List the component(s): ____________________________________

__ A documented history of a severe allergic reaction after a previous dose of the COVID-19 vaccine Please indicate to which vaccine the patient had a reaction and the date of the vaccine & reaction

- Moderna - Date of Vaccine & Reaction: ____
- Pfizer - Date of Vaccine & Reaction: ____
- Janssen/Johnson&Johnson - Date of Vaccine & Reaction: ________________________________

Option 2 – Physical Condition/Medical Circumstance

__ The physical condition of the patient or medical circumstances relating to the individual are such that immunization 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 immunization with the COVID-19 vaccine. Explanation:

Option 3 - Other

__Please provide this information in a narrative that describes, in detail, the medical condition or disability in detail that you believe would exempt this individual from vaccination:

Explanation:

Certification:

I certify that ________________________ (patient name) has the above contraindication and I support the request for a medical exemption from the COVID-19 vaccine requirement at Maine Maritime Academy
Provider Information:

Medical Provider Name: ____
Medical Provider Specialty: ____
Signature: ____
Provider License Number: _______________________ Date: ____________________________________
Name of Provider Company: ____
Address: ____
Email: ____
Phone Number: ____