Medical University of South Carolina

Immunization Exemption Request for Accommodation Form – Medical Exemption

Medical University of South Carolina is committed to protecting our patients, health care workers, volunteers, medical staff, employees, students, and the community from the spread of all vaccine preventable diseases. The Medical University of South Carolina requires that all individuals as defined in policy CHS-IPC-006 (Employee Student- Health Policy) to be vaccinated unless granted an accommodation approved through the Department of Organizational Engagement and Excellence. This form is used to request a medical accommodation.

****NOTE: Please complete this form in its entirety. Incomplete submissions may result in your request being denied. ****

Student's Information

Full Name: _____ Date of Birth: _____
Last *First* *M.I.*

Student Programs (no acronyms}: _____

Phone Number: _____ Email Address: _____

Address: _____
Street Address

_____
City State Zip Code

Does the student program require patient contact/ interaction? ☐ Yes or ☐ No

Furthermore, if your program contains a clinical component, your vaccination status may limit your access to some clinics and therefore could impact your matriculation through your program.

Have you taken any blood test to detect immunity against any vaccine preventable diseases? ☐ Yes or ☐ No
If Yes, which vaccines have you established immunity?

_____

_____

Accommodation Request

In the event of a disease outbreak, a student exempted from the Medical University of South Carolina's immunization requirements may be excluded from the university for the duration of the outbreak, both for his/her own protection and for the protection of others. Please check the box(es) below of all vaccine preventable diseases for which you are requesting an accommodation.

- ☐ **Diphtheria** (DTap, Tdap, Td)
- ☐ **Tetanus** (DTap, Tdap, Td)
- ☐ **Pertussis** (Whooping Cough) (DTAp, Tdap)
- ☐ **Measles** (MMR)
- ☐ **Mumps** (MMR)
- ☐ **Rubella** (German Measles) (MMR)
- ☐ **Polio**
- ☐ **Hepatitis B**
- ☐ **Hepatitis A**
- ☐ **Meningococcal**
- ☐ **COVID-19**
- ☐ **Influenza (Flu)**
- ☐ **Other**_____
- ☐ **Varicella** (Chicken pox)
  - ○ **Varicella Disease History:** I have had chicken pox, but was not diagnosed by licensed health care professional

Medical Accommodation

☐ Medical Accommodation – This accommodation requires a signature of a licensed physician qualified to make the diagnosis. **Please be sure to attach all supporting medical documentation.**

☐ Physician/Provider Instructions: By completing this form, you certify that different methods of vaccinating against vaccine preventable diseases have been considered, and that the following medical contradictions precludes any/some vaccinations.

Health care provider name (print): _____

Specialty: _____ Phone: _____ Fax: _____

Organization and address:

_____

_____

The following areas must be completed by the health care professional listed on this page

1. Diagnosis(es) and date(s):

_____

_____

2. Date last seen: _____

3. Current Status of condition(s) (e.g., active, progressing, controlled, in remission):

_____

_____

4. How long is this condition(s) likely to persist (be as specific as possible e.g., lifetime; 1 academic year; duration of academic program enrollment; 1 month): _____

5. Please list procedures/assessments used to diagnose this student's condition(s)

_____

_____

_____

_____

6. What effect will receiving the immunizations required by MUSC have on the student's medical condition?

_____

_____

_____

7. Has the student had any documented adverse reactions to any vaccinations in the past? If so, please explain the type of reaction and when it occurred.

_____

_____

_____

8. Other medical circumstance preventing vaccination with any available alternative vaccine (Be specific & describe in detail below)

_____

_____

_____

9. Identify any accommodations you believe may be necessary for the student to participate in the university's programs, activities, services and/or meet any clinical requirements.

_____
_____
_____
_____

10. List any medications related to this accommodation request only.

_____
_____

As the student's physician:

- I certify that this information is current and accurate to the best of my knowledge based on my recent evaluation of this patient or my review of records of a recent evaluation by a qualified health care provider.

- I certify that the physical condition of the student is such that the immunization checked above would endanger the health of the student.

  - ☐ This medical accommodation is permanent
  - ☐ This medical accommodation is temporary.
    Duration of accommodation: _____/_____/_____

I hereby request that this student exempted from the immunization requirements of the Medical University of South Carolina.

Signature of Treatment Provider:

_____

I certify under penalty of perjury, that I am a licensed medical professional and am qualified to make the above diagnoses.

License # _____

Date: _____

I hereby release the Medical University of South Carolina, its owners, staff, or representatives from any liability based on any health impairments resulting as a direct consequence of this exemption.

Signature & Date: _____

Thank you for your cooperation. You may fax or mail your report to the Department of Diversity, Equity and Inclusion at ***843-792-1288*** *or* ***169 Ashley Avenue, Hospital Suite [246], MSC 502 Charleston, SC 29425****.*

Please call Stephanie Price, Director of EEO, and Student Accessibility Services if you require additional information. Please attach any additional reports or relevant information. All information on this form will remain confidential in accordance with the Family Educational Rights and Privacy Act (FERPA).