FHS HEALTH PROFESSIONAL STUDENT COVID-19 VACCINE EXEMPTION REQUEST: MEDICAL EXEMPTION

PART 1 – STUDENT INFORMATION (To be completed by student)

Name: _____

Student Number: _____

Home Address: _____

City: _____ Prov. _____ Postal Code: _____

Telephone: _____

Email address: _____ Date of Birth: _____

Please indicate Program:

- □ Child Life
- □ Midwifery
- □ Nursing – Graduate
- □ Nursing – Undergraduate
- □ Physician Assistant
- □ Occupational Therapy
- □ Physiotherapy
- □ Speech Language Pathology
- □ Undergraduate Medicine
- □ Postgraduate Medicine

_____

Authorization and Consent to Release of Medical Information

I hereby request and authorize that medical information and related data pertaining to my current request for COVID-19 vaccine medical exemption be given to or discussed with the Faculty of Health Science Health Screening Office.

With this consent I authorize the FHS Health Screening Office to:

- Collect information related to the exemption request.
- If required, contact my treating physician or other medical practitioners for clarification of information and follow up, by telephone and/or correspondence, related to the circumstances regarding the reason(s) for the medical absence, but not limited to: assessments, consultations, referrals and testing.
- Provide my COVID-19 Vaccination Status and expected duration of approved exemption on a "need to know" basis and for the sole purpose of facilitating with my clinical educational requirements, with:
  - i. my program
  - ii. potential Placement site(s)
  - iii. Student Accessibility Services (if required)

Confidential medical information will not be discussed outside the parameters of this consent form without your separate, specific consent. Please note, the Faculty of Health Sciences is unable to reimburse you for any fee associated with completion of this form.

Please provide signed authorization below, include date and give this copy to your Physician for completion of Part 2. Return the completed form to:

McMaster FHS Health Screening Office
1280 Main Street West, HSC 3H46
Hamilton ON L8S 4K1
Email: hrsadmin@mcmaster.ca
Telephone: 905-525-9140 ext 22249
Fax: 905-528-4348
Upload Link: https://mcmasterhealthscreening.sharefile.com/share/filedrop

SIGNATURE		**Date:**

Student Name: _____	**Student Number:** _____

Please identify the medical exemption/accommodation(s) you are requesting:

_____

NOTE: If attending school in person, individuals who are medically unable to be vaccinated, may be required to engage in other health and safety measures, which may include but are not limited to: completing COVID-19 testing, wearing appropriate Personal Protective Equipment (PPE) and maintaining physical distancing.

PART 2 – COVID-19 VACCINE EXEMPTION REQUEST (To be completed by physician or RN (EC) – please print)

Attending Physician	HCP Name: _____ Profession: _____ Signature: _____ Date: _____	Office stamp or Address/Telephone

Please answer questions below as they relate to the requested exemption to COVID-19 vaccination.

1. Do you recommend this individual receive an approved COVID-19 vaccination?

Yes / No. Please provide medical rationale:

_____

_____

_____

2. Nature of the medical condition/injury/illness:

_____

_____

_____

3. Has maximum medical recovery been reached? Is further treatment recommended? Please explain and include the prognosis:

_____

_____

_____

4. Timelines: Do you consider this vaccine exemption as:

□ **Temporary with recommended end date or re-evaluation date: _____ OR**
□ **Permanent**