Faculty & Staff
Exemption Request Form – Seasonal Influenza Vaccine

Section I

This section to be completed by the Faculty/Staff requesting an exemption (Please complete all sections)

Name: ______________________________________ Date of birth

Department: ________________________________ Contact phone number: ________________________

I request an exemption from the seasonal influenza vaccination. Please indicate reason and sign below:

☐ **Medical Contraindication** *I understand that by requesting an exemption due to medical contraindications I will be required to provide documentation from my primary care physician. I also understand that the medical exemption must be based on standard criteria for medical exemptions recommended by the Centers for Disease Control and Prevention or Advisory Committees on Immunization Practices. See Section II.*

☐ **Religious Reasons**

I understand that by requesting an exemption due to religious beliefs I will be required to disclose the name of my religious affiliation. See Section III.

Signature:____ **Date:** ____________________________

Section II

This section is to be completed by the physician of the Faculty/Staff requesting an exemption for medical/pregnancy reasons.

Dear Physician,

Influenza vaccination is the most effective method of controlling the spread of influenza, Barnard College has mandated all Faculty & Staff must receive the influenza vaccine annually.

Your patient (named above) has requested a medical exemption. Medical exemptions are allowed based on recognized contraindications. Please complete the bottom portion of this form. If you have any questions, please contact the Office of Human Resources at hr@barnard.edu.

Physician Certification of Contraindication

I certify that my patient should not be vaccinated against influenza because of the following recognized contraindications:

☐ Documented anaphylactic allergic reaction or other severe adverse effect to the influenza vaccine- e.g., cardiovascular changes, respiratory distress, or other emergency medical attention to control symptoms.
Describe the specific reaction: ____

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☐ Documented allergy to a component of the vaccine – does not include allergic reaction to egg (egg-free vaccines are available), sore arm, local reaction or subsequent respiratory tract infection.
Describe the specific reaction: ____

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☐ Other/ Describe the specific reason____

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Physician Signature ___________________________________ **Date**____

Physician printed name ________________________________ **Phone#**______________________________________

Section III

This section is to be completed by an individual requesting a religious exemption.

Name of Religion ____________________________________

Email completed form to the Office of Human Resources mailbox @ hr@barnard.edu