STATEMENT OF MEDICAL EXEMPTION

MANDATORY VACCINATION FOR ATTENDANCE ON CAMPUS

SECTION 1 - INDIVIDUAL'S INFORMATION			
Last Name		First Name	
Unit Number	Street Number	Street Name	PO Box
City/Town		Province	Postal Code
Student/Employee ID #		If a student, please indicate whether you are a student of: ☐ Western University ☐ Brescia University College ☐ Huron University College King's University College	

Western University ("Western") requires that all students, faculty, staff and visitors who will attend on campus to be vaccinated against COVID-19, unless they have a valid exemption.

By submitting this form, I am asking that I be exempted from vaccination requirements due to a medical condition. I certify that the information below was completed by my physician or nurse practitioner.

I understand that should an outbreak occur, the Middlesex-London Public Health or Western may impose additional restrictions or requirements on me for health and safety reasons which may not apply to other students on campus who have been fully vaccinated.

I understand that Western will require me to be tested as set out in Western's COVID 19 Vaccination Policy and that I will be required to disclose my test results to Western in order to attend on campus.

I understand that Western may require me to follow additional health and safety protocols, including, but not limited to:

a. Masking and/or physical distancing; and/or
b. Remote working/learning.

SECTION 2 - Signature of Individual	
Signature	Date

SECTION 3 - Declaration of Physician or Nurse Practitioner

I, ____

(name of physician or nurse practitioner)

certify that, for medical reasons, the above named individual is unable to receive a COVID-19 immunization with the current COVID-19 vaccines available in Ontario (*Pfizer-BioNTech COVID-19 vaccine, Moderna COVID-19 vaccine, AstraZeneca/COVISHIELD COVID-19 vaccine*).

SECTION 4 – Condition and/or Adverse Event Following Immunization (select those that apply)	
A. Pre-Existing Condition(s)	
	Severe allergic reaction or anaphylaxis to a component of a COVID-19 vaccine
	Myocarditis prior to initiating a mRNA COVID-19 vaccine series (individuals aged 12-17 years old)
B. Contraindications to Initiating a AstraZeneca/ COVISHIELD COVID-19 Vaccine Series	
	History of capillary leak syndrome (CLS)
	History of cerebral venous sinus thrombosis (CVST) with thrombocytopenia
	History of heparin-induced thrombocytopenia (HIT)
	History of major venous and/or arterial thrombosis with thrombocytopenia following any vaccine
C. Adverse Events Following COVID-19 Immunization	
	Severe allergic reaction or anaphylaxis following a COVID-19 vaccine
	Thrombosis with thrombocytopenia syndrome (TTS)/Vaccine-Induced Immune Thrombotic Thrombocytopenia (VITT) following the Astra Zeneca/COVISHIELD COVID-19 vaccine
	Myocarditis or Pericarditis following a mRNA COVID-19 vaccine
	Serious adverse event following immunization (e.g. results in hospitalization, persistent or significant disability/incapacity)
D. Other	
	Actively receiving monoclonal antibody therapy OR convalescent plasma therapy for the treatment or prevention of COVID-19

SECTION 5 – Length of Exemption		
Permanent		
Time Limited	From: yyyy/mm/dd	To: yyyy/mm/dd

SECTION 6 - Signature of Physician or Nurse Practitioner			
Name of Physician or Nurse Practitioner			Registration/Licence No.
Business Address Unit Number	Street Number	Street Name	P.O. Box
City/Town	Province/State/Country		Postal Code
Signature of Physician or Nurse Practitioner		Date	

Personal information on this form is collected under the authority of the University of Western Ontario Act, 1982 (as amended), and will be used to determine the qualification of the individual identified on this form for medical exemption from the requirements of Western University's COVID-19 Vaccination Policy. Questions about this collection should be directed to Associate Legal Counsel (Privacy), 1151 Richmond Street, London, Ontario, N6A 3K7, (519)661-2111 ext. 84543, privacy.office@uwo.ca.