SUNY Cobleskill Beard Wellness Center
130 Albany Ave, Cobleskill, NY 12043

Phone: 518-255-5225
Fax: 518-255-5819

SUNY Cobleskill Beard Wellness Center
COVID-19 Vaccine
Medical Exemption Request Form

Section I: Student Information (to be completed by student or guardian, if student is under 18)

Last Name	First Name	Student Email	Date of Birth	800 #

☐ I understand that if I am not fully vaccinated against COVID-19, I will need to abide by all COVID-19 related health and safety restrictions if accessing a SUNY facility, including, but not limited to, use of face masks, physical distancing, participation in surveillance testing, quarantine and isolation.

☐ I acknowledge that my vaccination status will be verified through NYSIIS, CIR or my Wellness Center vaccination record.

Signature: _____ Date: _____

Student or guardian, only if under 18 years old after 8/12/2022

Section II: **Medical Exemption Request** (to be completed by medical provider)

Medical Provider Certification of Contraindication: I certify that my patient (named above) cannot be vaccinated against COVID-19 because of the following contraindication:

☐ Documented immediate (< 4 hours) or severe allergic reaction/anaphylaxis (e.g., hives, swelling of the mouth or throat, difficulty breathing, low blood pressure, or shock) after receiving a COVID vaccine or to any of the vaccine components:
Provide the name of the vaccine or the vaccine component and describe the reaction.

_____

_____

☐ History of thrombosis with thrombocytopenia.
Please explain, including date of diagnosis and presentation/complications.

_____

_____

☐ History of Multisystem Inflammatory Syndrome in Children (MIS-C) or Adults (MIS-A) after a confirmed SARS-CoV-2 infection or a COVID-19 vaccine.
Please explain, including date of diagnosis and manifestations/complications.

_____

_____

☐ Other medical based reason for medical exemption_____

_____

Healthcare Provider Information	**Date**
Name (print):	Address/Clinic Stamp:
Provider Signature:	Phone:

Once completed, students should email the signed form to wellnesscenter@cobleskill.edu, Fax to (518)255-5819 or mail to Beard Wellness Center, 130 Albany Ave, Cobleskill, NY 12043

Exemption request forms will be reviewed by committee. Decisions will be released through the secure messaging function of the Medicat Patient portal. Questions: Please contact Wellness Center at (518)255-5225.

Authorization to Release Information

SUNY Cobleskill Wellness Center
130 Albany Avenue • Cobleskill, New York 12043
Phone: 518-255-5225 • Fax: 518-255-5819

Name: ID#: DOB:
(Last) (First) (MI) (mm/dd/yy)

Authorization for information to be released by:

☑ SUNY Cobleskill Wellness Center

☐

(Name of individual / Title / Relationship or Organization

(Address/Phone/Fax)

Information to be released to:

☐ SUNY Cobleskill Beard Wellness Center - Attn:

☑ SUNY Cobleskill Religious Exemption Review Committee
(Name of individual / Title / Relationship or Organization)

(Address/Phone/Fax)

Do not disclose information regarding: ☐ HIV ☐ Alcohol /drugs ☐ Pregnancy

Information to be released:

- ☐ Complete medical/treatment record
- ☐ Consultation reports
- ■ Immunization record
- ☐ X-ray reports
- ☐ Physical Exam history
- ☐ Laboratory results
- ☐ Psychotherapy/treatment summary
- ☐ Treatment recommendations
- ☐ Verification of visit on: _____
- ☐ Verbal communication regarding:_____
- ☐ Other information or instructions (please specify):_____

Records pertaining to HIV tests/counseling require separate authorization for release.

Comment

I, the undersigned, have read the above and authorize the staff of the disclosing facility named to disclose such information as contained in this authorization. I understand that this release pertains only to treatment provided by the authorized parties, and does not include release of information received from other treatment providers. I understand that authorizing the disclosure of my health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure. I understand this authorization may be revoked, in writing at any time except to the extent that action has been taken in reliance on this authorization.

Unless otherwise revoked, this authorization will expire on the following date: _____, or 1 year from the date of the request if no date is specified.

As a result of COVID-19 restrictions, I have given verbal consent and am electronically signing this document with my name and campus identification number authorizing the release of information as indicated above.

Electronic Signature **Date**

800 Number