COVID-19 Vaccination Exemption Form
Request for Medical Exemption

Instructions for completing Medical Exemption Form:

- Section 1: Completed by parent/guardian or student (age ≥ 18 years).
- Section 2: Completed by licensed health care provider (MD, DO, ND, APRN-Rx, PA). Note: the University accepts vaccines approved for use by the World Health Organization or U.S. Food and Drug Administration.

SECTION 1: Student's Information			
Student's Name:	**Student's Date of Birth:**		
Student's Home Address:	**City:**	**State:**	**Zip Code:**
Name of Post-Secondary School/University: **Hawai'i Pacific University**	**Street Address:** **1 Aloha Tower Drive**	**City:** **Honolulu, HI**	**Zip Code:** **96813**
By signing below: I understand that by not receiving a vaccination, I may be susceptible to COVID-19 infection and may be at a greater risk of becoming ill. In addition, because of this continuing risk, the University may establish additional rules and restrictions for my protection and the protection of others around me, consistent with State orders and guidance from the CDC and other federal and state agencies. I hereby release the University from any and all claims related to the above. I understand that I will be required to comply with University safety protocols, rules, policies and procedures for unvaccinated students. I will comply with such University requirements, including mandatory testing. I agree to comply with all University policies and will immediately report any illness and comply with all isolation and quarantine requirements.			
Signature of Student: **Signature of Parent/Guardian for Student under 18:**	**Print Name:** **Print Name:**		**Date:** **Date:**

SECTION 2: Certification by Licensed Health Care Provider

I certify that in my medical judgement, due to the contraindication(s), and/or precaution(s) noted below, this student is exempt from receiving the specific COVID-19 vaccine(s) named for the period of time indicated below:

Description of Contraindication(s) (if applicable):

_____

Description of Precaution(s) (if applicable):

_____

Name of Vaccine(s): _____

This contraindication or precaution is: [ ] Permanent [ ] Temporary

If temporary, please provide length of time: _____

Health care provider's name/Title (Please Print): _____ License number: _____

Address: _____

Health care provider's signature: _____ Date: _____