House of Friendship

Statement of Medical Exemption: COVID-19 Immunization

Review the Medical Exemptions to COVID-19 Vaccination guidance prior to certifying a medical exemption to ensure all criteria are met.

Section 1 – Individual Information

Last Name	First Name	DOB (yyyy/mm/dd)

Home Address

Unit Number	Street Number	Street Name	PO Box

City/Town	Province	Postal Code

Section 2 – Declaration of Physician or Registered Nurse in the Extended Class (Nurse Practitioner)

I, _____ (Name of physician or registered nurse in the extended class) cerify 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).)

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Selection	Condition and/or Adverse Event Following Immunization
1. 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)
2. 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
3. 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)

4. Other

☐	Actively receiving monoclonal antibody therapy OR convalescent plasma therapy for the treatment or prevention of COVID-19

Section 3 - Length of Exemption

Permanent ☐		
Time limited ☐	From yyyy/mm/dd	To yyyy/mm/dd

Section 4 - Signature

Business Address

Unit Number	Street Number	Street Name	PO Box

City/Town	Province	Postal Code

Signature of Physician or Registered Nurse in the Extended Class	Designation	Date (yyyy/mm/dd)

Section 5 - Employee Consent to Disclose

I, _____ (your name) authorize, _____ (name of health professional) to disclose the information above to House of Friendship for the purposes outlined in Policy 13.0 COVID-19 Vaccine Policy. I understand that submitting this information to House of Friendship is voluntary, and that I can refuse to sign this consent.

_____, Dated: _____

(Signature)