College of Nursing

COLLEGE OF NURSING – MEDICAL/RELIGIOUS OBSERVATION
COVID DECLINATION FORM

Name:_____Date:_____
AccessID:_____Date of Birth: _____
Contact Phone Number: _____

Circle Level: UG GR Circle Program: Trad CD2 RNBSN MSN GRAD CERT DNP PhD

Other _____

STUDENT TO COMPLETE

Have you ever had a life-threatening allergic reaction after a dose of COVID-19 vaccine? ☐Yes ☐No
If Yes, please provide the manufacturer of the vaccine, approximate date of COVID-19 vaccine administration and a brief description of your allergic reaction: ___

_____

Have you ever had a life-threatening allergic reaction to any of the vaccine ingredients? ☐Yes ☐No
If Yes, name (s) of the ingredients: _____

Student Signature:_____Date:_____Time: _____

HEALTH CARE PROVIDER TO COMPLETE

A Michigan-licensed physician/practitioner to complete and sign request for exemption.

Students who have a medical condition that would prevent them from being able to receive vaccines must present documentation from their physician/practitioner to the College of Nursing, Office of Student Affairs to determine a true medical exemption.

Physician/Practitioner Statement: The above-named student of WSU College of Nursing is under my care. I have reviewed the Covid-19 vaccinerecommendations from the Centers for Disease Control (CDC) and request the following medical exemption based on a true medical contraindication as outlined by the CDC:

☐ Permanent Exemption related to:
- ☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose of Covid-19 vaccine
- ☐ History of anaphylactic reaction to Covid-19 vaccine ingredient: _____

☐ Temporary Exemption related to: ☐ Pregnancy ☐ Other _____
Student will be able to receive vaccine on or after (date): _____

Please Indicate Vaccine manufacturer(s) you are exempting student from: _____
Provider Name (print):_____MI Medical License #: _____
Address:_____Phone:_____
Signature:_____Date: _____
As options for the Covid vaccine expand, there may be vaccines available that will be medically safe for the student. The College of Nursing reserves the right to request recertification of this exemption.

RELIGIOUS/SPIRTUAL LEADER TO COMPLETE

Have you ever been exempted from getting a vaccine for religious/ spiritual reasons?
YES NO

Have you been given any vaccines within the past year? *

YES NO

If Yes, indicate name (s) of vaccine (s): _

Have your religious/spiritual beliefs changed in the past year? O Yes O No
If Yes, please give a brief description: _

Please explain why you are seeking a religious/spiritual exemption (use additional pages if necessary). You may be asked to talk about the nature of your beliefs.- -

ACADA determination of exemption request: Accepted Not Accepted

Signature:_____Date:_____

If you have questions, please contact the Office of Student Affairs.
Email a scanned copy of the completed form to nursinginfo@wayne.edu