



**COVID-19 Vaccination Requirement
Student Temporary Medical Deferral Exemption Request Form**

Student Name: _____ Student ID #: _____

School: _____

Anticipated Year of Graduation: _____

Please write your initials in the space next to “Acknowledged” to confirm that you have read and understand that statement.

Emory University requires COVID-19 vaccination of our students to prevent COVID-19 and its complications, including death. Acknowledged _____

By interacting with others in person, I could transmit COVID-19 at work to students, co-workers, and outside of work to my family and/or friends, even if I have no symptoms. Acknowledged _____.

I have received education about the effectiveness of COVID-19 vaccines, as well as possible side effects. Acknowledged _____.

I understand that I cannot get COVID-19 from the COVID-19 vaccine. Acknowledged _____.

I acknowledge my responsibility to only request a temporary exemption if truly necessary. Acknowledged _____

Even though I can receive the COVID-19 vaccine at no charge to myself, I want a temporary exemption from the vaccine. Acknowledged _____

In your student role, do you provide direct patient care? (Please select a response): Yes _____ No _____

Has Emory University Student Health Services granted you an exemption from any other mandatory vaccine requirement in the past? Yes _____ No _____

Please explain why you need a deferral. [This section must be completed]

What is the time period/end date for the deferral request? _____

Please attach supporting documentation from a licensed healthcare provider supporting your request. This should include medical records with medical reason or condition for the deferral and the anticipated duration of the need for deferral. Please submit your documentation with this completed form. Requests will not be considered without documentation.



A signature from a licensed healthcare provider below or on an attached document is required to validate a medical contraindication that defers the COVID-19 vaccine.

Physician Signature/Date:

Physician Name (Please Print):

Physician Contact Phone Number: _____

If approved, you agree to get a COVID-19 vaccine once the deferral period ends. Emory University will determine the end date.

I understand that my request for an exemption may not be granted if it is unreasonable, creates undue risk to university safety or if it creates an undue hardship for your school. Acknowledged _____

Date: _____ Student ID # _____

Print Name: _____ Signature _____

Please visit the [Student Health Patient Portal](#) to upload this form and submit your request. Please allow 3-5 business for review. You will receive confirmation of receipt and the decision regarding your submission through the portal via secure message.