Allegany College of Maryland
Allied Health Programs

Influenza Vaccination Exemption Request Form

Name: _____________________________________________ DOB: ____________________ Date: ____________________
(Please Print)

Allegany College of Maryland is committed to improving and protecting the health and well-being of our students, their families and the community.

I am requesting exemption for one of the following:
☐ Medical (Complete Part I)
☐ Religious (Complete Part II)

Part I - Please indicate applicable medical contraindications to the influenza vaccine:
☐ Previous severe reaction to influenza vaccine (e.g., hives, difficulty breathing, swelling of tongue or lips)
   Note: The above does not include sensitivity to the vaccine such as mild to moderate local reactions, soreness, redness, itching or swelling at the injection site, and/or slight ill feeling including upper respiratory infection or low-grade or moderate fever following a prior dose of the vaccine.
☐ History of Guillain-Barré Syndrome (GBS)
☐ Other

REQUIRED: Please provide an approximate date of your last reaction and a brief description: _________________________________________

NOTE: A severe egg allergy will not be accepted as a medical exemption as an egg-free vaccine is available

Part II – I attest that receiving the influenza vaccination would be against the tenets of my religious practice or the religious doctrine to which I subscribe.

☐ I attest to a religious exemption

Please indicate religious organization: __________________________________________________________________________________

I attest that the responses regarding my influenza medical/religious exemption are correct and accurate to the best of my knowledge. Allegany College of Maryland reserves the right to substantiate any of the above exemptions / contraindications and I agree to provide any additional supporting documentation if requested. I fully understand that any misrepresentation will result in corrective action up to and including termination from my selected program.

I also understand that I must wear a mask at all times while in a patient care or clinical care area within 6 feet of a patient during the influenza season.

Signature: _____________________________________________ Date_____________________

Notification of exemption approval/denial will be communicated via student email

Request an exemption via email to: ahvaccinewaiver@allegany.edu