

## Sample Statement of Medical Exemption COVID-19 Immunization- Public Use

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)
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#### Home Address

Unit Number	Street Number	Street Name	PO Box
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City/Town	Province	Postal Code
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### 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)

certify 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*).

Selection	Condition and/or Adverse Event Following Immunization
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#### 1. Pre-existing Condition(s)

	Severe allergic reaction or anaphylaxis to a component of a COVID-19 vaccine
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	Myocarditis prior to initiating a mRNA COVID-19 vaccine series (individuals aged 12-17 years old)
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#### 2. Contraindications to Initiating a AstraZeneca/ COVISHIELD COVID-19 Vaccine Series

	History of capillary leak syndrome (CLS)
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	History of cerebral venous sinus thrombosis (CVST) with thrombocytopenia
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	History of heparin-induced thrombocytopenia (HIT)
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	History of major venous and/or arterial thrombosis with thrombocytopenia following any vaccine
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### 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
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### Section 3 - Length of Exemption

Permanent					
Time limited	<table border="0" style="width: 100%;"> <tr> <td style="width: 50%;">From</td> <td style="width: 50%;">To</td> </tr> <tr> <td>yyyy/mm/dd</td> <td>yyyy/mm/dd</td> </tr> </table>	From	To	yyyy/mm/dd	yyyy/mm/dd
From	To				
yyyy/mm/dd	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)