Request for Exemption from COVID-19 Vaccination Requirement (for Student Participation in Athletics) Medical Exemption (9/2021)

Instructions for completing Medical Exemption Form:
Section 1: Completed by parent/guardian or student (aged > 18 years): Enter child care facility. school, or post-secondary school, and student information.
Section 2: Completed by licensed health care provider (MD, DO, ND, APRN-Rx, PA): Check exempted vaccine, contraindication or precaution, or both, and complete duration of exemption.

Section 1: Extracurricular Athletic Program. Secondary School and Student Information

Student's Full Name		Student's Date of Birth	
Student's Home Address	City	State	Zip
Name of School	Street Address	City	Zip

I understand the benefits and risks of the immunization my child is required to have for participation in extracurricular activities, the risk of my child contracting the diseases that the vaccine prevents, and the risk of my child transmitting disease to others.

I understand that the Hawai'i State Department of Education (Department) may at any time modify and/or revoke any accommodation(s) granted pursuant to this request for good cause. I understand that, absent a valid exemption from the vaccination requirement, I/my child will be excluded from participating in school-sanctioned athletic activities until the Department's vaccination policy for student-athletes is rescinded, or I/my child receive(s) the required vaccination.

Parent/Guardian Name [if student <18 years]. (Please print): _____

Parent/Guardian OR Student (if aged >18 years) Signature: _____ Date: _____

Section 2: For Health Care Provider Use ONLY (MD, DO, ND, APRN-Rx, PA):

Vaccine	CONTRAINDICATIONS* (Check all that apply)	PRECAUTIONS* (Check all that apply)	From:	To:
☐ COVID-19 Vaccine	☐ Severe allergic reactions (e.g. anaphylaxis) after a previous dose or to a vaccine component ☐ Immediate allergic reaction of any severity to a previous dose or known allergy to a component of the vaccine	☐ History of an immediate allergic reaction to a vaccine or injectable therapy ☐ Moderate to severe acute illness	/ / / /	/ / / /

☐ I certify that in my medical judgment, due to the contraindication(s)/precaution(s) noted above, this student is exempt from the specific vaccine named for the period indicated.

Additional notes: _____

Health care provider's name/Title (Please Print): _____ License number: _____

Address: _____

Health care provider's signature: _____ Date: _____