Lakes Regional Healthcare
An Avera Partner

COVID-19 Immunization Medical Exemption Request Form
Volunteer Form
Reference: Lakes Regional Healthcare Employee Health Policy

Volunteer Name: _____

Phone Number: _____

Email: _____

Dear Treating Medical Provider:

Lakes Regional Healthcare (LRH) requires the COVID-19 vaccine for adult volunteers over age 18. COVID-19 vaccines are safe and effective, and they may prevent severe illness, hospitalizations, and death. The above named person is requesting an exemption from LRH's vaccination requirement. Medical exemptions from the COVID-19 vaccination will be considered if the person provides a written certification by a licensed, treating medical provider (i.e., a physician, nurse practitioner, or physician assistant), of one of the following:

1. The applicable CDC contradiction for the required vaccine; or
2. The applicable contradiction found in the manufacturer's package insert for the required vaccine; or
3. A statement that the physical condition of the person or medical circumstances related to the person are such that immunization is not considered safe, indicating the specific nature and probable duration of the medical condition or circumstances that contradict immunization with the required vaccine.

Please complete the form below. If you have any questions, contact LRH Employee Health at (712) 336-8771.

Supporting documentation or a detailed narrative from the treating medical provider is required and should be attached to this form for an exemption to be granted.
The above person should not be vaccinated against COVID-19 for the following reasons (please check all that apply):

- ❑ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a component of the COVID-19 vaccine.
- ❑ Immediate allergic reaction of any severity to a previous dose or known (diagnosed) allergy to a component of the COVID-19 vaccine.
- ❑ Receipt of monoclonal antibodies or convalescent plasma as part of COVID-19 treatment within the last 90 days.
- ❑ Other (please specify)_____

By signing below, I hereby certify that (i) I am the treating medical provider for _____, (ii) I have performed an examination or have otherwise treated this person, and (iii) this person has the above contraindication(s) that supports a request for a medical exemption from the COVID-19 vaccination.

Provider's Signature: _____ Date: _____
(Note: Signature Stamp Not Acceptable)

Office Name: _____ Office Address: _____

Phone Number: _____

Once the above information is completed and signed by the provider, please provide to Occupational Health
All completed forms will be reviewed. Occupational Health will notify the student of the decision to grant the exemption (with or without conditions), deny the exemption, or request more information. Requests for exemptions will be kept confidential and shared only with those who need to know.

LRH HUMAN RESOURCES USE ONLY:

Medical Exemption **Approved** ☐

Medical Exemption **Denied** ☐ **Date:** _____/_____/_____