ChristianHorizons

COVID-19 Vaccination Medical Accommodation

(Please print clearly in ink)

TO BE COMPLETED BY EMPLOYEE / VOLUNTEER

Employee's Name: _____, _____ Phone No. _____ Work Location: _____ Supervisor: _____
(Last name first, in full)

Current Employee ☐ Volunteer ☐

Address: _____
(Street Number and Name) (Apt. No.) (City/Town) (Province) (Postal Code)

Date of Birth: _____ Language: ☐ E ☐ F ☐ Other Sex: ☐ M ☐ F ☐ Prefer not to disclose
Day Month Year

Please note:

- ***For current employees a supported Medical Accommodation exempts from vaccine education but does not exempt from ongoing rapid antigen testing***

CONSENT

I do, hereby authorize _____ (healthcare provider, licensed physician, medical practitioner, hospital, clinic) to disclose my medical and health information pertaining to my request for COVID-19 vaccination exemption to ***Christian Horizons, Human Resource Department.***

I understand that the aforementioned communication and information, portions thereof, and/or resulting recommendations that relate to my request for COVID-19 vaccination exemption may be used by Christian Horizons for the purposes of any one or more of the following:

1. Validating my request for COVID-19 vaccination exemption.
2. Providing necessary information for workplace accommodation if deemed appropriate with Christian Horizons.

A photocopy or facsimile of this authorization shall be as valid as the original.

By signing below, I consent to collection, use and disclosure of my personal information, including my health information, for the purposes as described above.

This consent is valid from the date signed until my COVID-19 vaccination exemption request is closed, or on the date my business relationship with Christian Horizons has been formally severed, whichever is earlier. It may be withdrawn at any time if I provide prior written notification to Christian Horizons.

_____ _____ _____
Employee/Volunteer's Name (Printed) Employee/Volunteer's Signature Date

TO BE COMPLETED BY ATTENDING PHYSICIAN

The patient is responsible for any charges made for completion of this form, unless prohibited by law.

Your patient is requesting a medical exemption from their prospective employer's COVID-19 vaccination program. A medical exemption may be allowed for certain recognized contraindications only. As outlined by the Ministry of Health Medical Exemptions to COVID-19 Vaccination Version 1.0 September 14, 2021 the following medical exemptions have been identified:

- Severe allergic reaction or anaphylaxis to a component of a COVID-19 vaccine
- Severe allergic reaction or anaphylaxis following a COVID-19 vaccine
- Myocarditis or Pericarditis following a mRNA COVID-19 vaccine
- Actively receiving monoclonal antibody therapy OR convalescent plasma therapy for the treatment or prevention of COVID-19

Please certify below by completing this form and detailing the medical reason that your patient should be exempt from COVID-19 vaccination. Supporting clinical documentation should be attached with your response**.**

Is the vaccination exemption permanent or time limited? _____

If time limited, indicate how long the exemption will last: _____

Current Employees: send completed form to *Acclaim* by email faxes@acclaimability.com or fax to 1-866-486-8663.

Version: September 18, 2021

Please advise which of the below is applicable for your patients COVID-19 vaccine exemption.

☐ **Option 1 – Severe allergic reaction or anaphylaxis to a component of a COVID-19 vaccine**

My patient has a documented history of a severe allergic reaction and/or anaphylaxis to any component of a COVID-19 or to a substance that is cross-reactive with a component. Please indicate which of the following vaccines are contraindicated and name the components, by vaccine. NOTE: since egg free vaccine is available, history of egg allergy will not be accepted as a routine medical exemption.

☐ Pfizer ☐ Moderna ☐ AstraZeneca

List the component(s):_____

☐ **Option 2 – Severe allergic reaction or anaphylaxis following a COVID-19 vaccine**

☐ Pfizer ☐ Moderna ☐ AstraZeneca Date of COVID-19 vaccine reaction: _____

List the component(s):_____

☐ **Option 3 – Myocarditis or Pericarditis following a mRNA COVID-19 vaccine**

The physical condition of the patient or medical circumstances relating to the individual are such that vaccination is not considered safe. Please state, with sufficient detail and include supporting clinical documentation, the specific nature and probable duration of the medical condition or circumstances that contraindicate vaccination with the COVID-19 vaccine.

Practitioner explanation for exemption:

_____
_____
_____
_____

☐ **Option 4 – Actively receiving monoclonal antibody therapy OR convalescent plasma therapy for the treatment/prevention of COVID-19**

The physical condition of the patient or medical circumstances relating to the individual are such that vaccination is not considered safe. Please state, with sufficient detail and include supporting clinical documentation, the specific nature and probable duration of the medical condition or circumstances that contraindicate vaccination with the COVID-19 vaccine.

Practitioner explanation for exemption:

_____
_____
_____
_____

CERTIFICATION

I certify that _____ (patient name) has the above contraindication and supports the request for a medical accommodation.

ATTENDING PHYSICIAN'S INFORMATION

Medical Provider Name: _____

Medical Provider Specialty: _____

Provider License Number: _____

Signature:_____ Date: _____

Address: _____

Telephone number: _____ Fax number: _____ Email: _____

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