Statement of Medical Exemption

COVID-19 Immunization

Version: February 17, 2022

Important Information Regarding Assessments for Medical Exemptions

- Statements of Medical Exemption **must** be submitted to the Public Health unit where the Physician or Registered Nurse in the Extended Class practices.
- True medical exemptions are expected to be infrequent and should be supported by expert consultation.
- Safe administration of subsequent doses of COVID-19 vaccine is often possible under the management of an appropriate physician, nurse practitioner or specialist. Additionally new types COVID-19 vaccines with different composition will be available in the near future providing alternatives for those with a documented true allergy to a component of current vaccines.
- Assessment for a medical exemption should include:
    - A detailed patient history,
    - Documentation of the adverse event/medical condition and supporting investigations for the diagnosis,
    - Individualized risk benefit analysis,
    - Recommendations/options for future immunization.
- Referral and specialist consultation support is available through Ontario's eConsult Service, OTN Hub, and the Special Immunization Clinic (SIC) Network.
    - Ontario eConsult - https://econsultontario.ca/
    - Ontario Telemedicine Network (OTN) - https://otn.ca/
    - Special Immunization Clinic (SIC) Network - https://cirnetwork.ca/sic-network-patient-referrals/

How to Submit for Review and Entry into COVax

1. Review the **Medical Exemptions to COVID-19 Vaccination** guidance prior to certifying a medical exemption to ensure all criteria are met.
2. Complete and collect the necessary documents:
    a) Statement of Medical Exemption
        - Completed by the client's primary care provider or a physician with a specialty in an area related to the reason for exemption (i.e., Cardiologist, Allergist etc.).
        - All sections MUST be completed
    b) Supporting documents from the medical exemption assessment (i.e., patient history, consultation notes etc.)
    c) ***Client Information and Consent Form***

- Completed and signed by the client

3. Fax all documents to the WDGPH RD Fax Line1-855-934-5463.
   NOTE - Submissions that are missing required information will not be reviewed.

Section 1- Client Information

Last Name	First Name	Gender	Health Card Number	DOB (yyyy/mm/dd)

Home Address

Unit Number	Street Number	Street Name	PO Box

City/Town	Province	Postal Code	Telephone

Section 2 – Declaration of Submitter (i.e. - Physician or Registered Nurse in the Extended Class (Nurse Practitioner))

I, _____

(Print name of physician or registered nurse in the extended class)

certify that, for medical reasons (specified below), the above-named client 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).

Reason for the Exemption Request	
1. Pre-existing Conditions ☐ Severe allergic reaction or anaphylaxis to a component of a COVID-19 vaccine ☐ Myocarditis prior to initiating a mRNA COVID-19 vaccine series that is still being followed clinically.	Provide Detail:

2. Contraindications to Initiating an AstraZeneca / COVISHIELD or Janssen COVID-19 Vaccine Series ☐ History of capillary leak syndrome (CLS) ☐ History of cerebral venous sinus thrombosis (CVST) with thrombocytopenia ☐ History of heparin-induced thrombocytopenia (HIT) ☐ History of major venous and/or arterial thrombosis with thrombocytopenia	Provide Detail:
3. Adverse Events Following COVID-19 Immunization ☐ Documented severe allergic reaction or anaphylaxis following a COVID-19 vaccine (provide documentation) ☐ Thrombosis with thrombocytopenia syndrome (TTS)/Vaccine-Induced Immune Thrombotic Thrombocytopenia (VITT) following the Astra Zeneca/COVISHIELD or Janssen COVID-19 vaccine ☐ Myocarditis or *Pericarditis following an mRNA COVID-19 vaccine ☐ Serious adverse event following immunization where appropriate medical evaluation has determined that the individual is unable to receive any COVID-19 vaccine (please provide documentation)	Provide Detail: *NACI guidance, post pericarditis clients can receive the vaccine 90 days post recovery so only require a time-limited exemption.
4. Other ☐ Actively receiving monoclonal antibody therapy OR convalescent plasma therapy for the treatment or prevention of COVID-19 ☐ Actively receiving or recently completed immunosuppressing therapy anticipated to significantly blunt vaccine response	Provide Detail and attach documentation:

Section 3 - Duration of Exemption

Exemption Duration:	Provide Details:
☐ Time Limited ☐ Permanent (Note – Permanent Exemptions are very rare)	a) Justify duration of exemption b) If "Time Limited", specify start and end dates: • start date (YYYY/MM/DD): _____ / _____ / _____ • end date (YYYY/MM/DD): _____ / _____ / _____

Section 4 –Submitter Information

Name of Physician or Registered Nurse in the Extended Class (Please Print)	CPSO or CNO Number

Business Address

Unit Number	Street Number	Street Name	PO Box

Phone Number	Fax Number	
City/Town	Province	Postal Code
Signature of Physician or Registered Nurse in the Extended Class	Designation	Date (yyyy/mm/dd)