

# Statement of Medical Exemption

## COVID-19 Immunization

Version: January 26, 2022

### Important Information Regarding Assessments for Medical Exemptions

- 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 Line 1-855-934-5463.

NOTE - Submissions that are missing required information will not be reviewed.

<b>Section 1- Client Information</b>				
Last Name	First Name	Gender	Health Card Number	DOB (yyyy/mm/dd)
<b>Home Address</b>				
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).

<b>Reason for the Exemption Request</b>	
<p><b>1. Pre-existing Conditions</b></p> <p><input type="checkbox"/> Severe allergic reaction or anaphylaxis to a component of a COVID-19 vaccine</p> <p><input type="checkbox"/> Myocarditis prior to initiating a mRNA COVID-19 vaccine series that is still being followed clinically.</p>	<p>Provide Detail:</p>

**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:

Time Limited

Permanent

(Note – Permanent Exemptions  
are very rare)

Provide Details:

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)