Northeast Team Handball League
c. 2009

COVID-19 VACCINATION
MEDICAL EXEMPTION REQUEST FORM

If you have an allergy to the COVID-19 vaccine or a specific medical condition that precludes the COVID-19 vaccination requirement and you seek a medical exemption from the Northeast Team Handball League's COVID-19 vaccination requirement, please consult with your physician and complete/upload this form (with supporting documentation) to the NTHL Health Portal.

Confidentiality of Information Provided - Requests for exemptions and any documents provided will be kept confidential.

NAME

DATE OF BIRTH

TEAM

EMAIL ADDRESS

PHYSICIAN INFORMATION

PHYSICIAN NAME

PHYSICIAN PHONE#

PHYSICIAN ADDRESS

Dear Physician,

The Northeast Team Handball League (NTHL) requires COVID-19 vaccinations for all students, faculty and staff. A medical exemption from COVID-19 vaccination is allowed for certain recognized contraindications *(https://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html)*. **Please complete the form below. Thank you.**

The individual listed above should **not be** immunized for COVID-19 for the following reasons (Check all that apply)

Severe allergic reason (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 vaccine (Vaccine ingredients: *https://www.cdc.gov/vaccines/covid-19/info-by product/clinical-considerations.html#Appendix-C*)

a. Which ingredient caused an allergic reaction?_____

b. What was the reaction? _____

c. Which brand of the COVID-19 vaccine is contraindicated and why?_____

d. How long will the medical contraindication last? _____

Other Medical Reason – Please provide a detailed separate narrative that describes any other medical reason(s) justifying an exemption.

PHYSICIAN'S AUTHORIZATION

I certify that [individual's name] _____ has the medical condition checked and request a medical exemption from COVID-19 vaccination.

Physician's Signature: _____ Date: _____
*NOTE: Signature Stamp is **not** accepted)*

Physician's Medical License # _____ NPI No: _____

FOR THE REQUESTOR

Verification and Accuracy:

I verify that the above information I have provided is complete and accurate to the best of my knowledge, and I understand that any intentional misrepresentation contained in this request may result in ineligibility for all future NTHL events. I also understand that my request for an exemption may not be granted if it is unreasonable or creates an undue hardship for the NTHL.

Printed Name: _____ Date: _____

Signature: _____

Signature of Parent or Guardian (if under 18)_____

Printed Name:_____ Date:_____