

**Statement of Medical Exemption
COVID-19 Immunization- Public Use**

Review the [Medical Exemptions to COVID-19 Vaccination](#) guidance prior to certifying a medical exemption to ensure all criteria are met.

Refer to the Medical and Clinical Trial Exemptions: Guidance for Issuing and Entering Records into COVaxON for information on entering exemption records into COVaxON and obtaining patient consent for this purpose. If you require a copy of this guidance, please contact your Public Health Unit, the Ministry of Health, or your Regulatory College. Please see Appendix 1 to this form for best practices for obtaining consent as well as sample consent and attestation forms.

Section 1 – Individual Information

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

Home Address

Unit Number	Street Number	Street Name	PO Box
City/Town	Province		Postal Code
Email Address (Optional)		Mobile Phone Number (Optional)	

Section 2 – Substitute Decision Maker Information (if applicable)

Name	Relationship to Individual	Phone number
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Section 3 – Declaration of Physician or Registered Nurse in the Extended Class (Nurse Practitioner)

I, _____, (Name of physician or registered nurse in the extended class)

certify that, for medical reasons, the above named individual 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 COVID-19 vaccine, Janssen vaccine*).

Selection	Condition and/or Adverse Event Following Immunization
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1. Pre-existing Condition(s)

	Myocarditis prior to initiating a mRNA COVID-19 vaccine series (individuals aged 12-17 years old)
	Severe allergic reaction (including anaphylaxis) to a component of a COVID-19 vaccine

2. Contraindications to Initiating an AstraZeneca 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 following any vaccine

3. Adverse Events Following COVID-19 Immunization

	Thrombosis with thrombocytopenia syndrome (TTS)/Vaccine-Induced Immune Thrombotic Thrombocytopenia (VITT) following the Astra Zeneca or Janssen COVID-19 vaccine
	Myocarditis or Pericarditis following a mRNA COVID-19 vaccine
	Severe allergic reaction (including anaphylaxis) following a COVID-19 vaccine
	Serious adverse event following COVID-19 immunization (e.g. results in hospitalization, persistent or significant disability/incapacity)

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

Section 4 – Exemption End Date

Date (yyyy/mm/dd)

Section 5 - Signature

Business Address

Unit Number	Street Number	Street Name	PO Box
City/Town		Province	Postal Code
Email Address or Phone Number		Public Health Unit	Designation
Signature of Physician or Registered Nurse in the Extended Class		Registered Practitioner Number	Date (yyyy/mm/dd)

APPENDIX 1: Consent

Best Practices for Obtaining Consent to Collect, Use, and Disclose Personal Health Information

- Where possible, the health information custodian (HIC) should obtain signed written consent from the individual to whom the information relates or their substitute decision maker.
- The HIC may alternatively obtain consent verbally and submit a written attestation signed by the HIC.
- HIC's should ensure that the consent satisfies the conditions set out in the [Personal Health Information Protection Act, 2004](#).

Sample Consent

I _____ have provided information regarding a medical exemption from receiving a COVID-19 vaccination. I consent to the information being collected, used, and disclosed for the following purposes:

- The information will be collected by my medical practitioner for the purpose of maintaining my health care record.
- The information will be disclosed to an Ontario public health unit to create a record of personal health information indicating my exemption from COVID-19 immunization.
- The information may be exchanged between my medical practitioner and the public health unit as may be needed to clarify or verify my exemption.
- It will be used and disclosed as required for the administration of Ontario's COVID-19 vaccination program as well as other purposes authorized and required by law. For example,
 - It will be disclosed to the Chief Medical Officer of Health and Ontario public health units where the disclosure is necessary for a purpose of the *Health Protection and Promotion Act*.
 - It may be disclosed, as part of my provincial electronic health record, to health care providers who are providing care to me.

Information disclosed to the Ontario public health units will be stored in a health record system under the custody and control of the Ministry of Health.

You may also be contacted by a hospital, local public health unit, or the Ministry of Health or its agent for purposes related to your medical exemption (for example, to check on the status of your exemption). If you wish to receive these follow up communications by email or text, please indicate this using the box below.

I consent to receiving follow-up communications:

by email

by text/SMS

If you consent to provide information regarding your medical exemption from receiving a COVID-19 vaccination, and then change your mind, you may withdraw consent at any time. Withdrawing your consent does not have retroactive effect but would prohibit the Ministry's subsequent uses of your personal health information unless authorized by law. If you wish to withdraw your consent or have questions about doing so you may contact the Ministry of Health at vaccine@ontario.ca.

Signature

Date

Sample Attestation

I, _____ (HIC) hereby attest that _____ (individual) has provided me with personal health information regarding their medical exemption from receiving a COVID-19 vaccination and that the individual has consented to the information being collected, used, and disclosed in a manner that meets the requirements of the *Personal Health Information Protection Act, 2004*. The consent was:

1. Provided by the individual to whom the information relates or their substitute decision-maker.
2. Knowledgeable in that the individual understands the purpose of the collection, use or disclosure and know that they can give or withhold consent.
3. Relates to the information that is being collected, used or disclosed
4. Was not obtained through deception or coercion.

The individual was informed that the personal health information is being collected to maintain the individual's health care record and is being disclosed to the Public Health Unit(s) to create a record indicating their exemption from COVID-19 immunization.

The individual was informed that their personal health information will be stored in a health record system under the custody and control of the Ministry of Health and will be securely held and only used or disclosed as authorized by law including:

- Disclosure to the Chief Medical Officer of Health and Ontario public health units where the disclosure is necessary for a purpose of the *Health Protection and Promotion Act*.
- Disclosure, as part of the patient's provincial electronic health record, to health care providers

Signature

Date