PROMIC
Professionals for Medical Informed Consent and Non-Discrimination

v1.0821/2

Adults and children over 12

HEALTH PROFESSIONAL-DECLARED
COVID-19 VACCINATION EXEMPTION FORM

As the undersigned health professional, to the best of my knowledge and belief based on information I have determined or have been provided with by the individual in question, or if the individual in question is under 16, by a parent or guardian on their behalf, I can confirm that the following individual should be exempted from COVID-19 vaccination owing to medical concerns.

Details of exempted individual

Full name (first name and surname):

Home address:

City: County/state:

Postal/zip code: Country:

Contact telephone: Contact email:

Date of birth (dd/mm/yyyy) [if relevant]:

Nationality [if relevant]:

Passport number [if relevant]:

Any additional information relating to Covid-19 vaccine exemption

Following consultation with the named individual, I have recommended that COVID-19 vaccination be avoided for the following reason or reasons.

[Check all boxes that apply]

- ☐ This person has a personal and/or familial medical history of allergic or anaphylactic reactions to foods, medications, vaccines or environmental chemicals
- ☐ This person has a personal and/or familial medical history of one or more autoimmune conditions or diseases
- ☐ This person has a medical history of clotting/bleeding disorders and, in my professional opinion, COVID-19 vaccination is contraindicated
- ☐ This person has a personal and/or familial medical history of chronic fatigue syndrome (CFS), myalgic encephalomyelitis (ME) or other post-viral condition(s)
- ☐ This person has a personal and/or familial medical history of a neurological or inflammatory disease or condition
- ☐ This person has a medical condition or health concern for which, in my professional opinion, COVID-19 vaccination is contraindicated
- ☐ This person has contraindication given concerns about the as-yet unknown long-term effects of COVID-19 vaccines on fertility
- ☐ This person has previously had COVID-19 and has, or is likely to have, acquired natural immunity
- ☐ This person is using evidence-based health or medical measures to protect self and others from infection by SARS-CoV-2

HEALTH PROFESSIONAL DECLARATION

As the undersigned, I hereby declare that to the best of my knowledge and belief the above information is true and correct. I have consulted with the above named individual, or if the individual in question is under 16, with a parent or guardian on the individual's behalf, and I recommend that this person be exempt from COVID-19 vaccination. This is my professional opinion and is based on my professional medical practice guidelines for decision-making and consent.

Health professional name in full: Qualification(s):

Registration body: Registration ID (if appropriate):

Signature: Date: