JB Pritzker
Governor

Rob Jeffreys
Director

**The Illinois Department of Corrections**

1301 Concordia Court, P.O. Box 19277 • Springfield, IL 62794-9277 • (217) 558-2200 TDD: (800) 526-0844

# REQUEST FOR MEDICAL EXEMPTION FROM COVID-19 VACCINATION

If you have an allergy to the COVID-19 vaccine or a specific, documented medical condition that precludes you from receiving the COVID-19 vaccine and you seek a medical exemption from the COVID- 19 vaccination requirement, please consult with your physician and provide the following information.

**Please print the following information:**

Name/DOB: _____

Name/ID # of Individual(s) in custody: _____

Current Facility: _____

Physician Name: _____

Physician Phone No.: _____

Physician Address: _____

_____

Dear Physician:

The Illinois Department of Corrections requires COVID-19 vaccinations for all visitors. A medical exemption from COVID-19 vaccination is allowed for certain recognized contraindications (https://www.cdc.gov/vaccines/covid-19/info-by- product/clinicalconsiderations.html).

Please complete the form below. Thank you.

The above person should not be immunized for COVID-19 for the following reasons (Please check all that apply):

- ❑ Severe allergic reaction (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:

Which ingredient caused an allergic reaction? _____

What was the reaction? _____

_____

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

_____

_____

How long will the medical contraindication last? _____

_____

Please provide any medical records that document the date of the prior vaccine and the reaction thereto.

- ❑ Other Medical Reason – Please provide this information in a separate narrative that describes the other medical reason(s) justifying an exemption in detail. Please include reference materials (websites maintained by the C.D.C. or other government agencies, publications by medical associations, articles in medical journals, scientific studies, etc.) that support the medical exemption requested.

## For the Physician:

I certify that _____ has the above contraindication or specific medical condition and request a medical exemption from COVID-19 vaccination.

**Physician Signature:** _____

**Date:** _____

**(Note: Signature Stamp Not Acceptable)**

**Physician Medical License No.:** _____ **NPI No.:** _____

## For the Visitor:

I affirm that the above information I have provided is complete and accurate. I understand that, if granted an exemption, I must comply with the mitigation measures required of me by the Illinois Department of Corrections. Such measures include but are not limited to: wearing face masks (including N95, KN95, and surgical masks), and maintaining certain physical distancing as determined by the agency. I understand that I may be required to curtail certain activities if the

agency determines that the participation of unvaccinated individuals in those activities presents an unreasonable risk to the facility. I understand that my request for an exemption may not be granted or may be modified or rescinded to minimize the risk to the facility. I understand that any misrepresentation contained in this request may result in suspension of my visitation privileges.

**Signature: _____**

**Date: _____**

**Print Name: _____**

**Position: _____**

**Confidentiality of Information Provided**

Requests for exemptions and any documents provided will be kept confidential and shared only with those employees who have a need to know.

**Please forward this correspondence to**

**IDOC Legal Services**
**1301 Concordia Court PO Box 19277**
**Springfield, IL 62794**
**OR**
**DOC.VisitorRequest@Illinois.gov**