



### Request for Exemption of COVID-19 Vaccine

I understand that immunization is an effective way to protect against serious preventable diseases. I also understand the risk of non-immunization, particularly in a group setting such as a university campus. I understand that the COVID-19 virus is a highly contagious respiratory virus that can cause serious medical problems and even death. According to scientific data, COVID-19 vaccines are safe and highly effective at preventing serious illness, hospitalization, and death. I request an exemption from the University of Dayton's admission requirement that all students show proof of vaccination against COVID-19 for the following reasons:

\_\_\_\_ Religious

\_\_\_\_ Medical

\_\_\_\_ Philosophical

I, undersigned student, understand that if I contract this disease while a student at the University of Dayton, my name will be released to appropriate public health authorities including the Ohio Department of Health and I will be asked to leave campus or isolate per University isolation and quarantine protocols, during the period of communicability. I also understand that if I am considered a close contact of someone diagnosed with COVID 19, I may be prohibited from attending classes or using University facilities, INCLUDING RESIDENTIAL FACILITIES, during the incubation period of the disease at the direction of the University of Dayton or appropriate public health authorities including the Ohio Department of Health.

I understand the risks of non-immunization and hold harmless the University of Dayton and the Ohio Department of Health (including appropriate public health authorities) from any responsibility for adverse consequences of my refusal to be immunized against COVID-19, including but not limited to contracting this disease, having a serious complication of COVID-19 including death, financial loss, and inability to complete course requirements or participate in other University activities that may have stricter requirements.

Date \_\_\_\_\_ Print Name \_\_\_\_\_

Student Signature \_\_\_\_\_

Student ID# \_\_\_\_\_ Date of Birth \_\_\_\_\_

Date \_\_\_\_\_ Parent or legal guardian \_\_\_\_\_  
(If student is under 18 years of age)

\*Please return completed form via email [healthcenter@udayton.edu](mailto:healthcenter@udayton.edu), fax 937-229-3107, or mail to 300 College Park, Dayton, OH 45469-0900.