SUNY Cobleskill COVID-19 Vaccine
Religious Exemption Request Form

Section I: Student Information
(to be completed by student or guardian, if student is under 18 years old after 1/20/2023)

Last Name	First Name	Student Email	Date of Birth	800#

Section II: Religious Beliefs Exemption Request
(to be completed by student or guardian, if student is under 18 years old after 1/20/2023)

Requests for exemption based on religious beliefs: Students who hold genuine and sincere religious beliefs contrary to the COVID-19 vaccination may be exempt after submitting a written statement which includes an explanation of how receiving the COVID-19 vaccination conflicts with the student's sincere religious belief or practice, and (2) certify how not receiving the COVID-19 vaccination will not otherwise prevent the students' completion of the programmatic or curricular requirement of their academic program.

Student statement:

____
____
____
____
____
____
____
____

☐ I certify that if I am exposed to or test positive for COVID-19 I know that I will be quarantined or isolated per NYS Department of Health Guidelines and will not be allowed to attend in person classes.

☐ I understand that if I am not fully vaccinated against COVID-19, I will need to abide by all COVID-19 related health and safety restrictions if accessing a SUNY facility, including, but not limited to, use of face masks, social distancing, participation in surveillance testing, quarantine, and isolation.

☐ I acknowledge that my vaccination status will be verified through my SUNY Cobleskill vaccination record and have completed the Authorization for Release of Information form attached.

Signature:____ Date:____
Student or guardian, only if under 18 years old after 1/20/2023

Once completed, students should email the signed form to wellnesscenter@cobleskill.edu, Fax to (518)255-5819 or mail to Beard Wellness Center, 130 Albany Ave, Cobleskill, NY 12043

Exemption request forms will be reviewed by a committee.

Authorization to Release Information

SUNY Cobleskill Wellness Center
130 Albany Avenue • Cobleskill, New York 12043
Phone: 518-255-5225 • Fax: 518-255-5819

Name: ID#: DOB:
(Last) (First) (MI) (mm/dd/yy)

Authorization for information to be released by:

SUNY Cobleskill Wellness Center

(Name of individual / Title / Relationship or Organization

(Address/Phone/Fax)

Information to be released to:

SUNY Cobleskill Beard Wellness Center - Attn:

(Name of individual / Title / Relationship or Organization)

(Address/Phone/Fax)

Do not disclose information regarding: ☐ HIV ☐ Alcohol /drugs ☐ Pregnancy

Information to be released:

- ☐ Complete medical/treatment record
- ☐ Consultation reports
- ☐ Immunization record
- ☐ X-ray reports
- ☐ Physical Exam history
- ☐ Laboratory results
- ☐ Psychotherapy/treatment summary
- ☐ Treatment recommendations
- ☐ Verification of visit on: ___________________
- ☐ Verbal communication regarding:____
- ☐ Other information or instructions (please specify):__________________________________

Records pertaining to HIV tests/counseling require separate authorization for release.

Comment

I, the undersigned, have read the above and authorize the staff of the disclosing facility named to disclose such information as contained in this authorization. I understand that this release pertains only to treatment provided by the authorized parties, and does not include release of information received from other treatment providers. I understand that authorizing the disclosure of my health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure. I understand this authorization may be revoked, in writing at any time except to the extent that action has been taken in reliance on this authorization.

Unless otherwise revoked, this authorization will expire on the following date: ______________________, or 1 year from the date of the request if no date is specified.

As a result of COVID-19 restrictions, I have given verbal consent and am electronically signing this document with my name and campus identification number authorizing the release of information as indicated above.

Electronic Signature **Date**

800 Number