

Fall 20\_\_

Spring 20\_\_

Summer 20\_\_



UNIVERSITY of HAWAII®  
SYSTEM

## Request for Temporary Medical Exemption from COVID-19 Testing (For *Unvaccinated* Students)

In order to be eligible to return to campus after being diagnosed with a recent COVID-19 infection you must complete this form and submit this and the following to your campus Covid-19 Response team (you can find a list here: <https://www.hawaii.edu/covid19/covid-19-info-by-campuses/>) via [UH File Drop](#) (<https://www.hawaii.edu/filedrop/>) services.

1. Provide a copy of initial positive COVID-19 test result or a letter from a medical provider documenting test result/and or onset of illness date.
2. Letter from medical provider with date of release from isolation and clearance to return to campus.

All documents must be on official medical provider-issued letterhead and submitted with this form for processing. Please allow a week for processing.

### SECTION A: *To be completed by student (and/or legal parent/guardian)*

Student's Name: \_\_\_\_\_ UH ID/Username: \_\_\_\_\_

Phone: \_\_\_\_\_ UH Email Address: \_\_\_\_\_ UH Home Campus: \_\_\_\_\_

I am also a University of Hawaii faculty/staff member.

**By signing below:** I understand that as I have recently (within the last 90 days) tested positive for COVID-19, I will be considered exempt from the testing requirement for 90 days from the date of my positive case. I understand that I may not return to campus or attend any in-person activities until I am officially cleared by my medical provider and should isolate for the recommended duration as advised by my medical provider. I further understand that once cleared by my medical provider, I must continue to comply with University rules and regulations pertaining to COVID-19.

Student's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Date: \_\_\_\_\_

[if student is <18 years]

Parent/Guardian Signature: \_\_\_\_\_

### SECTION B: *To be completed by Healthcare Professional ONLY (MD, DO, APRN-Rx, PA)*

Date of positive laboratory-confirmed (RT-PCR or antigen) COVID-19 infection: \_\_\_\_\_ (Date)

This exemption from testing begins/began on: \_\_\_\_\_ and ends on: \_\_\_\_\_  
(date: Year/Mo/Day) (date: Year/Mo/Day - 90 days from test)

Student is/was cleared to return to campus [*after their required 10 day isolation and without fever for 24 hours and resolution of symptoms*] on: \_\_\_\_\_ (Date)

I certify that this student is considered compliant for 90 days from the date of the positive case.

Healthcare Professional Name/Title (print) \_\_\_\_\_ Healthcare Professional Signature \_\_\_\_\_ Date \_\_\_\_\_

Address: \_\_\_\_\_ License Number: \_\_\_\_\_

### For Office Use Only:

Effective Term: \_\_\_\_\_ Processed By: \_\_\_\_\_ Processed Date: \_\_\_\_\_