Goodwin University

APOI

Appendix A - Proof of Measles, Mumps, Rubella, and Varicella Immunization

STUDENT INFORMATION

Full name *Last* *First*

Student ID number Birthdate *MM/DD/YYYY* / /

Address

City *State* *ZIP code*

Email Phone

As required by Connecticut state law, the following immunizations are required for all students born after December 31, 1956: Measles (2 doses), Rubella (2 doses), and Mumps (2 doses). In addition, the following vaccination is required for all students born on or after January 1, 1980: Varicella (2 doses).

	Date of 1st dose (MM/DD/YYYY)	Date of 2nd dose (MM/DD/YYYY)	Check this box if you plan to file for an exemption from this vaccine	
Measles			☐	
Rubella			☐	
Mumps			☐	
Varicella			☐	☐ **Check this box if you were born before January 1, 1980 and therefore do not require this vaccine**

THIS SECTION IS TO BE FILLED OUT BY THE MEDICAL PHYSICIAN OR ADVANCED PRACTICE REGISTERED NURSE (APRN)

I certify that the above information is correct according to the above student's medical records.

Print name of medical physician or APRN Date

Signature of medical physician or APRN Physician/APRN contact email or phone number

Goodwin University

BPOI

Appendix B - Immunization Exemption Form

STUDENT INFORMATION

Full name *Last* *First*

Student ID number Birthdate *MM/DD/YYYY* / /

Address

City *State* *ZIP code*

Email Phone

I AM REQUESTING A MEDICAL EXEMPTION FROM THE FOLLOWING IMMUNIZATIONS:

☐ Measles ☐ Mumps ☐ Rubella ☐ Varicella

If you are requesting an exemption from any immunization for a medical reason, please select from the options below and provide the requested supporting medical documentation as indicated.

☐ I am requesting a medical exemption because the immunization/s as indicated above is/are medically contraindicated. I will provide documentation from a medical physician or advanced practice registered nurse (APRN) that such immunization is medically contraindicated.

☐ I am requesting a medical exemption because I have had a confirmed case of the disease/s indicated above. I will provide medical documentation from a medical physician or APRN, or the director of health of my current or former town of residence indicating that I had a confirmed case of the respective disease or I will provide documentation of a titer test.

I UNDERSTAND AND AGREE TO THE FOLLOWING IF MY EXEMPTION IS ACCEPTED:

That by filing for an exemption to the Immunization Policy, I will not be allowed on campus in the event of an outbreak for the duration of the outbreak for a disease that I am not immunized for as required by law and indicated in my records, and I will accept any of the associated consequences.

That should I be exposed to a disease for which I am not immunized for as required by law and indicated in my records, I agree to notify the University and understand that I will not be allowed on campus until it has been determined that it is medically safe for me and the University community, and I will accept any of the associated consequences.

Signature of student Date

Signature of parent or guardian if student is under the age of 18 years Date

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THIS SECTION IS TO BE FILLED OUT BY THE MEDICAL PHYSICIAN OR ADVANCED PRACTICE REGISTERED NURSE (APRN)

I certify that the above information is correct according to the above student's medical records.

Print name of medical physician or APRN Date

Signature of medical physician or APRN Medical physician/APRN contact email or phone number

Physician or APRN license number