

Appendix B - Immunization Exemption Form

STUDENT INFORMATION

Full name <i>Last</i>	<i>First</i>
Student ID number	Birthdate <i>MM/DD/YYYY</i> / /
Address	
<i>City</i>	<i>State</i> <i>ZIP code</i>
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

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	