



# Instructions for filing for a medical exemption from submitting proof of Immunization.

The [Immunization Handbook for Postsecondary Institutions](#) provides the following information regarding Medical Exemptions for students:

## Medical Exemption

A licensed physician, physician assistant, or nurse practitioner, or licensed midwife for a pregnant student certifies in writing that the student has a health condition which is a contraindication to receiving a specific vaccine, that a permanent or temporary (for resolvable conditions such as pregnancy) exemption may be granted. This statement specifies those immunizations which may be detrimental and the length of time they may be detrimental. Provisions need to be made to review records of temporarily exempted persons periodically to see if contraindications still exist. In the event of an outbreak, medically exempt individuals should be protected from exposure. This may include exclusion from classes.

In general, the following persons should not receive Measles, Mumps, or Rubella vaccine without checking with a doctor.

- ‡ 3 UHYLRXV DQDSK\ODFWLF UHDFWLRQ WR WKL V YDFFLQH RU WR DQ\ RI LW
- ‡ 3 UHJQDQF\ RU SRVVLELQW\ RI SUHJQDQF\ ZLWKLQ ZNV
- ‡ 6 HYHUH LP RYXQ, genital fibroids; receiving chemotherapy; congenital immunodeficiency; long-term immunosuppressive therapy; or severely symptomatic HIV).

Note: HIV infection is NOT a contraindication to MMR for those who are not severely immunocompromised

# REQUEST FOR MEDICAL EXEMPTION TO IMMUNIZATION FORM

This form must be submitted for all requests for exemption from immunization requirements. Please review Instructions for filing for a medical exemption from submitting proof of Immunization. In the event of an outbreak, medical exempt individuals may be inhibited from physical campus access.

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

In addition to this form, provide a signed statement from a licensed physician, physician assistant, or nurse practitioner, or licensed midwife specifying the immunizations which are detrimental to your health and the length of time these immunizations may be waived. The statement must be signed within the last two years.

### Health Care Provider Info

Name: \_\_\_\_\_  
Address \_\_\_\_\_  
Phone # \_\_\_\_\_

Health Care Provider License Number &  
or Stamp:

Waiver effective until \_\_\_\_\_

\_\_\_\_ Confirm that you have read the following What You Need to Know documents

[What You Need to Know Measles, Mumps, Rubella Vaccines](#)

[What You Need to Know Meningococcal Vaccine](#)

I hereby affirm the truthfulness of the forgoing statement.

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Guardian Signature, if student is under 18 years of age

\_\_\_\_\_  
Date

PLEASE COMPLETE, SIGN AND UPLOAD THIS FORM TO UNIVERSITY HEALTHCARE'S SECURE PATIENT PORTAL