Immunizations: Certificate of Medical Exemption

Patient's Name: _____

If legal name differs from chosen name, please note aka here: _____

Patient's Birthdate: _____

Notice: This form may be used to exempt a student from the requirement of vaccination when a health care practitioner has determined specific vaccination is not advisable for the individual for medical reasons. This form must be completed and signed by the health care professional. The exempted student may be excluded from campus activities, including in person class attendance, during an outbreak of the disease they have not been fully vaccinated against.

Medical Provider: Please indicate which vaccination/s the medical exemption is referring to by disease. If the patient is not exempt from certain vaccinations, mark as "not exempt."

Disease	Not Exempt	Permanent Exempt	Temporary Exempt	Expiration Date for Temporary Medical Exemption
Measles	☐	☐	☐	
Mumps	☐	☐	☐	
Rubella	☐	☐	☐	
Hepatitis B (for those under age 19)	☐	☐	☐	
Varicella (chickenpox)	☐	☐	☐	
Tetanus, Diphtheria & Pertussis (Tdap)	☐	☐	☐	
COVID-19	☐	☐	☐	

Medical reason/s for which this/these exemption/s are based: _____

_____

Medical Provider Declaration

I declare that vaccination for the disease/s checked above is/are not advisable for the above named individual. I have discussed the benefits and risks of immunizations with the individual as a condition for exempting them. I certify that I am a qualified and licensed MD, ND, DO, NP, or PA and that the information provided on this form is complete and correct.

_____ _____ _____

Licensed Health Care Provider (print) Licensed Provider (signature) Date

Address of Practice: _____

☐ **MD** ☐ **ND** ☐ **DO** ☐ **NP** ☐ **PA** _____

State of licensure and license #