# **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 that 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) | **** | **** | **** |  |
| COVID-19 | **** | **** | **** |  |
| Meningococcal Conjugate (ages 16-21) | **** | **** | **** |  |

**Medical Provider Declaration**

I declare that vaccination for the disease/s checked above is/are not advisable for the above named individual due to contraindications. I have discussed the benefits and risks of immunizations with the individual. I certify that I am a qualified and licensed health care professional and that the information provided on this form is complete and correct.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of Licensure (MD, DO, NP, PA, Psychologist, etc.); State of licensure; and License Number