University Immunization Medical Exemption Form

UNIVERSITY OF THE PACIFIC

CERTIFICATE OF MEDICAL EXEMPTION

Immunization Requirements

Student's Name _____ ID# _____ Birth Date _____

A. **Check box for which an exemption is being claimed:** *One vaccine per medical exemption certificate*

☐ **INFLUENZA** ☐ **VARICELLA** ☐ **MMR** ☐ **TDAP** ☐ **COVID** ☐ **MENINGOCOCCAL CONJUGATE**

OTHER: _____

In the event of a disease outbreak you may not be allowed on campus. The period of exclusion may be for a few days up to several months and may extend to two incubation periods after the last case depending upon the disease and the number of cases.

B. To be completed by Medical Provider:

I, _____ [Name of licensed MD, DO, PA, NP] certify that the above-named student has:

☐ A medical condition that contraindicates his/her vaccination with _____ vaccine

Please check the appropriate box and list below either:

a) ☐ The applicable CDC contraindication to this vaccine*, or

b) ☐ The applicable manufacturer's vaccine insert contraindication to this vaccine*, or

c) ☐ The physical condition of the person or medical circumstances relating to the person that are such that immunization is not considered safe, indicating the specific nature of the medical condition or circumstances* that contraindicate immunization with this vaccine*

*REQUIRED: **Description of contraindication meeting criteria a, b, or c above:**

_____

_____

_____

This contraindication is: ☐ Permanent or ☐ Temporary

If temporary: The expiration date of the exemption for this vaccine is: _____

Titers for immunity to this disease: (attach laboratory results)

☐ Indicate that he/she is immune ☐ Indicate he/she is NOT immune ☐ Have not yet been obtained

(Provider stamp here)

_____
Physician Signature

_____
Physician License Number

_____
Date

_____
Parent Signature (*required if student is under 18 years)*

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