# Woodbury University Medical Exemption Request Form

Full Name of Student: Phone #:

Campus Student Attends: ☐ Burbank ☐ San Diego

Student ID Number:

Student's Date of Birth: Email:

**I understand that by signing below, I acknowledge that I am / my student (is) aware of the potential consequences of being unvaccinated, including contracting a potentially serious vaccine-preventable disease and transmitting it to others, academic failure and even withdrawal from the school as a result of the disease. I also understand that in case of a disease outbreak, I / my student may be temporarily excluded from campus for my / my student's protection as a result of my / my student's lack of immunity. I hold no one but myself responsible for my declination and the consequence of me / my student being unvaccinated.**

Student's Signature Date

Signature of Parent/Guardian/Conservator Date

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I, _____ [Name of licensed MD, DO, PA, NP ] have reviewed the Woodbury University's Immunization Policy, and hereby 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: (list only 1 vaccine per section)

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: (Please attach photocopies of any titer results if done)

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

☐ A medical condition that contraindicates his/her vaccination with ___vaccine:

Please check the appropriate box and list below either: (list only 1 vaccine per section)

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: (Please attach photocopies of any titer results if done)

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

☐ A medical condition that contraindicates his/her vaccination with _vaccine:

Please check the appropriate box and list below either: (list only 1 vaccine per section)

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: (Please attach photocopies of any titer results if done)

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

☐ A medical condition that contraindicates his/her vaccination with _vaccine:

Please check the appropriate box and list below either: (list only 1 vaccine per section)

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: (Please attach photocopies of any titer results if done)

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

| Signature of Medical Provider: | Date: | Medical License Number & State/Country of Issue: |
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| Practice Address: | Provider Phone Number & Email: |
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***Students: Return this completed form to the Student Health Office.***

| For Use by Woodbury University Student Health Staff Only: | Campus: |
|---|---|
| Date Recieved: | Notes: |
| Date Approved | |
| Date Denied | |