University of California Medical Exemption Request Form

Full Name of Student: ____________________________

Campus Student Attends: ____________________________

Student’s Medical Record Number: ____________________________

Student’s Date of Birth: ____________________________

I, ____________________________ [Name of licensed MD, DO, PA, NP] have reviewed the University of California Immunization Exemption 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: In how many months may this vaccine be given? ____________________________

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 |

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If temporary: In how many months may this vaccine be given? ____________________________

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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:

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This contraindication is: ☐ Permanent or ☐ Temporary

If temporary: In how many months may this vaccine be given? ______________________________

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 Healthcare Provider: __________________________
Date: __________________________ Medical License Number & State/Country of Issue: __________________________

Practice Address: __________________________ Provider Phone Number & Email: __________________________

Students: Return this completed form to the Student Health Service at the UC campus where you attend.

For Use by University of California Student Health Staff Only:

☐ Date Approved: __________________________
☐ Date Denied: __________________________
☐ Date of Entry into PnC: __________________________

Campus: __________________________
Address: __________________________