

## MEDICAL EXEMPTION REQUEST FORM

Full Name of Student \_\_\_\_\_ Phone# \_\_\_\_\_

Student's CSUEB NetID ID# \_\_\_\_\_ Student's Date of Birth: \_\_\_\_\_

I, \_\_\_\_\_ (*Name of Licensed, US board certified MD, DO, PA, NP*) have reviewed the CSU immunization requirements and hereby certify that the above named student has a medical condition that contraindicates their vaccination with the following vaccine(s): (mark all that apply)

- MMR ( Measles, Mumps and Rubella)     Tdap (Tetanus, Diphtheria and pertussis)     Hepatitis B
- Meningococcal conjugate (Serogroups A, C, Y, & W-135)     Varicella (chicken pox)

The physical condition of the person or medical circumstances relating to the person are such that immunization is not considered safe. The specific nature of the medical condition or circumstances that contraindicate immunization with this vaccine(s) are indicated below.

**REQUIRED:** Description of contraindication:

---

---

---

This contraindication is  Permanent or  Temporary

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

Signature of Medical Provider: \_\_\_\_\_ Date: \_\_\_\_\_ US Medical License Number & State/Country of Issue: \_\_\_\_\_

Practice Address: \_\_\_\_\_

Provider Phone Number & Email: \_\_\_\_\_

Disclaimer: Medical Exemptions are evaluated on a case by case basis. Medical records may be requested by SHC for review prior to granting a medical exemption.

In active infectious disease outbreak situations, I, \_\_\_\_\_ (print student name), may not be allowed to come to campus or I may have to leave the residence halls. I understand these situations will be determined on a case by case basis and in consultation with state and local public health officials.

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Medical Practice Stamp:**