

MEDICAL EXEMPTION REQUEST FORM

Student Name: _____ Student ID #: _____

Student Date of Birth: _____ Date: _____

I, _____ (Name of licensed MD, DO, PA NP) have reviewed the California State University, Sacramento Immunization Exemption Policy, and hereby certify that the above-name 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 contraindicates to this vaccine,* or
- b) The applicable manufacturer's vaccine insert contraindication to this vaccine,* or
 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
- c) 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, 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

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Signature of Medical Provider

Date:

Medical License Number & State/Country of Issue:

Practice Address:

Provider Phone Number & Email

Students: Return this completed form to Sacramento State Student Health & Counseling Services

For Use by Sacramento State Student Health & Counseling Staff Only:

Date Approved:

Date Denied:

Date of Entry to EHR: