CALIFORNIA STATE UNIVERSITY
SACRAMENTO

Flu Vaccine Exemption Form

Name of Student: _____

Date of Birth: _____ Student ID #: _____

Name of Healthcare Provider: _____

License Number: _____ Expiration Date: _____

State of Issuance: _____

License Type: ☐ Medical or Osteopathic Physician ☐ Nurse Practitioner ☐ Physician's Assistant

Practice Address: _____

Email: _____ Phone: _____

I hereby certify that the above-referenced patient qualifies for a medical exemption from _____ (Enter year, i.e., 2022-23) seasonal influenza vaccine, as further provided below:

Reason for Exemption:

☐ CDC Contraindication ☐ CDC Precaution ☐ Manufacturer's Insert Contraindication

This contraindication or precaution is: ☐ Permanent ☐ Temporary

If temporary, the expiration date is: _____

_____

Signature of Healthcare Provider Date

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

For Official Use Only:

☐ Approved ☐ Denied Date: _____

Name: _____ Title: _____

Signature: _____