

**STATEMENT OF EXEMPTIONS TO IMMUNIZATION**

NAME \_\_\_\_\_

BIRTH DATE \_\_\_\_\_ STUDENT ID # \_\_\_\_\_

ADDRESS \_\_\_\_\_

The administration of immunizing agents conflicts with my medical and/or religious beliefs. I understand that in the event of an outbreak of vaccine-preventable disease, the Health Director may exclude me from the university community for my own protection. This exclusion will last until an incubation period from the last identified case of the communicable disease has passed.

**Medical Exemption:** The physical condition of the above-named person is such that immunization would endanger life or health, or is medically contraindicated due to other medical conditions.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
(Physician/APRN)

Phone Number and Address \_\_\_\_\_  
 \_\_\_\_\_

**Religious Exemption:** Parent or legal guardian of the above-named person or the person himself/herself is adherent to a religious belief opposed to immunizations.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
(Parent, Legal Guardian, Emancipated Student or Student, 18 years and older)

Phone Number and Address \_\_\_\_\_  
 \_\_\_\_\_

I hereby affirm that this affidavit was signed in my presence on this \_\_\_\_\_ day of \_\_\_\_\_ month \_\_\_\_\_ year.

\_\_\_\_\_  
 Notary Public

\_\_\_\_\_  
 Phone Number and Address

\_\_\_\_\_

