# STUDENT IMMUNIZATION EXEMPTION REQUEST FORM

Full Name: ______________________________ PID: _____________________ Date of Birth: _____________________

**Part A: Request for Exception Based on Medical Exemption**

The above-named person has a medical condition that contraindicates their vaccination with the following vaccine(s):

- ☐ MMR (Measles, Mumps, & Rubella)
- ☐ Meningococcal conjugate
- ☐ Tdap
- ☐ Varicella
- ☐ COVID-19 (SARS-CoV-2) vaccines
- ☐ Influenza
- ☐ Other: ____________________

Please check the appropriate box to indicate the reason for the medical exemption request:

- ☐ The applicable CDC contraindication or precaution to this/these vaccine(s)*, or
- ☐ The applicable manufacturer's vaccine insert contraindication or precaution to this/these vaccine(s)*, or

*The contraindication and/or precaution is: Permanent Temporary, the expected end date is:______________

*REQUIRED description of contraindication:

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

I understand that I must comply with the Non-Pharmaceutical Interventions (e.g., face coverings, regular asymptomatic testing) for unvaccinated or not fully vaccinated individuals as a condition of my Physical Presence at any University Location/Facility or Program. These required Non-Pharmaceutical Interventions are defined by my Location's public health, environmental health and safety, occupational health, or infection prevention authorities, including the Location Vaccine Authority. I also understand that I must comply with any additional Non-Pharmaceutical Interventions applicable to my circumstances or position, as required by my Location. **BY SIGNING BELOW, I CERTIFY THAT I HAVE BEEN INFORMED OF THE RISKS OF COVID-19 INFECTION, INCLUDING LONG-TERM DISABILITY AND DEATH, BOTH FOR MYSELF AND FOR OTHERS WHOM I MAY EXPOSE TO THE DISEASE.**

______________________________________
Student Signature

I, ______________________________________ [Name of licensed MD, DO, PA, NP] have reviewed the University of California Immunization Exemption Policy, and hereby certify the above.

______________________________________ ________________________
Signature of Licensed Healthcare Provider Date

______________________________________ ________________________
Printed Name of Healthcare Provider / License No. MD/DO/PA/NP