CSUDH | HEALTH & WELL-BEING

REQUEST FOR MEDICAL EXEMPTION

Student Name:_____ Date of Birth:_____

Student ID#:_____ Phone #:_____

A. MEDICAL EXEMPTION REQUEST

□ MMR (Measles, Mumps, & Rubella)
□ Hepatitis B
□ Tdap
□ Other_____
□ COVID-19 (SARS-COV-2)
□ Varicella (Chicken Pox)
□ Meningococcal conjugate

B. MEDICAL EXEMPTION TO BE COMPLETED BY MEDICAL PROVIDER:

I, _____ (name of licensed, board-certified MD, DO, PA, NP) have reviewed the CSUHD Immunization Exemption Policy, and herby certify the student stated above has a medical condition that contraindicates their vaccination with the vaccine(s) indicated above.

PLEASE CHECK THE APPROPRIATE BOX:

□ The applicable CDC contraindication to their vaccine, or

□ The applicable manufacturer's vaccine insert contraindication to the vaccines, or

□ 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 contraindicates immunization with these vaccines are indicated below.

REQUIRED- Description of Contraindications:

_____

_____

_____

The contraindication is: □ Permanent □ Temporary- (Expected End Date):_____

Medical Provider Signature:_____

Print Name:_____

License No._____

Date:_____

(Provider Stamp)

C. STUDENT ACKNOWLEDGEMENT:

In the event of an active infectious disease outbreak, I understand an exempt student may not be allowed on campus, and may be asked to leave the residence hall. I understand these situations will be determined on a case-by-case basis, and in consultation with state and local public health guidelines.

Student Signature or
Parent/Guardian:_____ Date:_____
(if student is under 18 years of age)