Santa Clara University
Medical Immunization Exemption Request Form

Full Name of Student: ____

Student's SCU ID#: ____________________ **Living:** ☐ **On Campus** ☐ **Off Campus**

Student's Date of Birth (MM/DD/YEAR): ______________ Student Cell # __________

I,_______________________________[Name of licensed MD, DO, PA, NP] have reviewed the Santa Clara University Immunization Policy on page 4, and hereby certify that the above-named 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 contraindication to this vaccine*, or
b) ☐ The applicable manufacturer's vaccine insert contraindication to this vaccine*, or
c) ☐ 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 circumstances* that contraindicate immunization with this vaccine*

***REQUIRED: Description of contraindication meeting criteria a, b, or c above:**

____

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This contraindication is: ☐ Permanent or ☐ Temporary
If temporary: the 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 the person is immune ☐ Indicate the person is NOT immune ☐ Have not yet been obtained

☐ 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 contraindication to this vaccine*, or
b) ☐ The applicable manufacturer's vaccine insert contraindication to this vaccine*, or
c) ☐ 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 circumstances* that contraindicate immunization with this vaccine*

***REQUIRED: Description of contraindication meeting criteria a, b, or c above:**

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This contraindication is: ☐ Permanent or ☐ Temporary
If temporary: the 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 the person is immune ☐ Indicate the person is NOT immune ☐ Have not yet been obtained

☐ 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 contraindication to this vaccine*, or
b) ☐ The applicable manufacturer's vaccine insert contraindication to this vaccine*, or
c) ☐ 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 circumstances* that contraindicate immunization with this vaccine*

***REQUIRED: Description of contraindication meeting criteria a, b, or c above:**

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This contraindication is: ☐ Permanent or ☐ Temporary
If temporary: the 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 the person is immune ☐ Indicate the person is NOT immune ☐ Have not yet been obtained

☐ 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 contraindication to this vaccine*, or
b) ☐ The applicable manufacturer's vaccine insert contraindication to this vaccine*, or
c) ☐ 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 circumstances* that contraindicate immunization with this vaccine*

***REQUIRED: Description of contraindication meeting criteria a, b, or c above:**

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This contraindication is: ☐ Permanent or ☐ Temporary
If temporary: the 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 the person is immune ☐ Indicate the person is NOT immune ☐ Have not yet been obtained

Signature of Medical Provider:____ Date: _________________________________

Medical License Number & State/Country of Issue: ____

Practice Address: ____

Provider Phone Number & Email:

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Students: Return this completed form to the Santa Clara University Cowell Center or the MySCU Portal (https://www.scu.edu/apps/login/).Click on the Cowell Center/My Student Health Portal

An unvaccinated student without natural immunity is at greater risk of becoming ill with the vaccine- preventable disease. An unvaccinated student that does not have documentation of immunity may be excluded from attending school during an emergency, or during an outbreak of, or after exposure to, any of these diseases: Measles, Mumps, Varicella (chickenpox), Meningicoccal Meningitis or COVID19. These decisions may be made in consultation with appropriate local and state authorities.

I understand this Medical Exemption and have had the opportunity to ask questions about it. I verify the truth and accuracy of my statements in this Medical Exemption Form and acknowledge that declining a vaccination may require my departure from campus under certain circumstances.

If the medical exemption is temporary, I agree to submit the proper documentation showing proof of required immunization once the medical exemption has expired.

Student Name (Print): ____

Student Signature: ____

Parent Signature: ____

(Parent/Guardian Signature required if student is under 18 years old)