**Student Health and Counseling Center**
(714) 278-2800 / Fax (714) 278-5525

# IMMUNIZATION WAIVER FORM

Name: ______________________________ CWID #: __________________________________

DOB: _______________________________ Phone: ___________________________________

## Measles/Rubella (MMR)

Medical: ☐ Allergy to eggs
☐ Current pregnancy confirmed.
Due date: ___________________.
☐ Letter from private medical doctor.
Reason:_____________________.
☐ Met with SHCC Provider.
Reason: _____________________.
☐ Other. Explain:__________________

______________________________

Personal/Religious/Philosophical:
☐ Need more time to obtain records.
Time requested:______________
☐ Contrary to religious beliefs.
☐ Contrary to personal/philosophical beliefs.
☐ Other. Explain: ________________

______________________________

I agree to hold harmless the Trustees of the California State University in the event of any possible illness or injury resulting from waiving or delaying my immunization requirement.

Student Signature*: _________________________

Date: _____________________________________

*If under 18, parent or guardian signature:

___________________________________________

## Hepatitis B

Medical: ☐ Previous adverse reaction to hepatitis B vaccine.
Reaction: ___________________
☐ Letter from private medical doctor.
Reason: ____________________.
☐ Met with SHCC Provider.
Reason: _____________________.
☐ Other. Explain:__________________

______________________________

Personal/Religious/Philosophical:
☐ Need more time to obtain records.
Time requested:______________
☐ Contrary to religious beliefs.
☐ Contrary to personal/philosophical beliefs.
☐ Other. Explain: ________________

______________________________

I agree to hold harmless the Trustees of the California State University in the event of any possible illness or injury resulting from waiving or delaying my immunization requirement.

Student Signature*: _________________________

Date: _____________________________________

*If under 18, parent or guardian signature:

___________________________________________

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**Waiver approved by: ____________________ on ________ ☐ Perm ☐ Temp ______**
Name Date Until

**Code(R-religious, W-medical, T-temp)______ Entered in SIS+_______ MedPro________**
Date Date