San Francisco State University - IMMUNIZATION REQUIREMENTS MEDICAL WAIVER REQUEST FORM

All students must provide proof of immunization before they may register for classes.
The SHS recommends that students keep up to date with all recommended vaccinations

http://www.cdc.gov/vaccines/adults/rec-vac/college.html

Note: Students who were enrolled in a California public school for the seventh grade or higher on or after July 1, 1999 *DO NOT* currently have to complete and submit this form to provide proof of immunization against Measles, Rubella and Hepatitis B BUT Students are advised to do so as the requirements may change in the very near future.

LAST NAME ______________________ FIRST NAME ______________________ M.I.__________

ADDRESS____

PHONE NUMBER(S)______________________________________ DATE OF BIRTH______________

STUDENT ID # _______________ SFSU E-MAIL__________________________ MAJOR________________

Please complete this form OR Attach a copy of your Medical Waiver Request Documentation

Mail or Bring this form in person to:	**Questions?**
Registrar's Office, SSB 101 **San Francisco State University** **1600 Holloway Avenue** **San Francisco, CA 94132**	**Registrar, One Stop** **Student Service Center, SSB 101** **Phone: 415-338-2350** **FAX: 415-338-0588** **http://health.sfsu.edu/required.html**
SF State Vaccination Requirements	
ALL STUDENTS* BORN ON OR AFTER January 1, 1957	STUDENTS 18 YEARS OR YOUNGER
Measles, Mumps, Rubella (MMR) Vaccine (2 Doses) OR **Results of a blood test indicating immunity** If you were born before 1957, check with your academic department to see if immunizations are needed for curriculum requirements.	Hepatitis B Vaccine (3 Doses) Also NEED Proof of MMR Vaccination – See Previous Column
I hereby certify that for medical reasons I recommend that the above named patient should not be vaccinated against Measles, Mumps, Rubella (MMR). ☐ Permanent Recommendation ☐ Temporary Recommendation ending __________ Date	**I hereby certify that for medical reasons I recommend that the above named patient should not be vaccinated against Hepatitis B (HepB).** ☐ Permanent Recommendation ☐ Temporary Recommendation ending __________ Date
CERTIFICATION BY MD / NP / PA / RN Name________________________________ Address______________________________ Date________________ License #_______	**CERTIFICATION BY MD / NP / PA / RN** Name________________________________ Address______________________________ Date________________ License #_______

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FOR RELIGIOUS/PERSONAL WAIVERS/EXEMPTION REQUESTS – CONTACT REGISTRARS OFFICE (SEE ABOVE)
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