University of California Medical Exemption Request Form

BERKELEY • DAVIS • IRVINE • LOS ANGELES • MERCED • RIVERSIDE • SAN DIEGO • SAN FRANCISCO • SANTA BARBARA • SANTA CRUZ

Full Name of Student: _____

Campus Student Attends: _____

Student's Medical Record Number: _____

Student's Date of Birth: _____

I, _____ [Name of licensed MD, DO, PA, NP] have reviewed the University of California Immunization Exemption Policy, 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:**

_____

_____

_____

_____

This contraindication is: ☐ Permanent or ☐ Temporary

If temporary: In how many months may this vaccine be given? _____

Titers for immunity to this disease: (Please attach photocopies of any titer results if done)

Indicate that he/she is immune ☐ Indicate he/she 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

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Indicate that he/she is immune ☐ Indicate he/she is NOT immune ☐ Have not yet been obtained

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If temporary: In how many months may this vaccine be given? _____

Titers for immunity to this disease: (Please attach photocopies of any titer results if done)

Indicate that he/she is immune ☐ Indicate he/she is NOT immune ☐ Have not yet been obtained

Signature of Healthcare Provider: Date: Medical License Number & State/Country of Issue:

Practice Address: Provider Phone Number & Email:

Students: Return this completed form to the Student Health Service at the UC campus where you attend.

For Use by University of California Student Health Staff Only:

☐ Date Approved: _____

☐ Date Denied: _____

☐ Date of Entry into PnC: _____

Campus: _____

Address: _____

_____

_____