

SXU Health Center

3925 W. 103rd St

Chicago, IL 60655

Phone: 773-298-3712

Fax: 773-298-3906

**REQUEST FOR MEDICAL EXEMPTION FROM VACCINATION(S)**

*Please print the following information:*

|  |  |  |  |
| --- | --- | --- | --- |
| Name | | Date of Birth | SXU ID |
| Primary Phone Number ( ) | **E-mail** | | |

*The following form must be filled out and signed by a licensed Healthcare Provider in order to be considered valid.*

**Dear Healthcare Provider:**

The State of Illinois requires all full-time university students to submit required immunization records. If the above named individual is unable to receive any of the required immunization(s), please provide information about the medical contraindications below:

1. Please check any required vaccine(s) your patient is unable to receive due to medical contraindication:

□ MMR (measles, mumps, rubella)

□ Meningococcal conjugate (Brand names: Menveo, Menactra, MenQuadfi)

□ Tdap (tetanus-diphtheria-pertussis) □ Td (tetanus-diphtheria) □ Dtap

□ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check any highly recommended (but not required) vaccine(s) your patient is unable to receive due to medical contraindication:

□ Pfizer or Moderna COVID-19 vaccine □ Johnson & Johnson COVID-19 vaccine

□ Meningococcal Serotype B (Brand names: Trumenba, Bexsero)

□ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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2. Please describe why this individual cannot receive the above indicated vaccine(s) due to medical contraindication (if you need more space, please attach documentation):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Is this medical contraindication permanent? □ Yes □ No

•If this medical contraindication is not permanent, please provide a date that your patient would be able to

receive the vaccine(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For the Healthcare Provider:**

I am a physician (MD or DO), nurse practitioner or physician assistant who is licensed to practice medicine in the jurisdiction of the United States.

By signing below, I affirm that I have a patient relationship to the individual named above and that providing any of the above named contraindicated vaccine(s) could be detrimental to this individual’s health.

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Clinic Stamp:

License number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State of Licensure: \_\_\_\_\_\_

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For the Requestor:**

I affirm that the above information is complete and accurate. I understand that if there is an infectious disease outbreak on campus that I do not have adequate protection for (i.e. a mumps outbreak and you do not have mumps immunity) I may need to be excluded from campus activities, including classes, until it is deemed safe for you to return by public health authorities.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**To turn in this medical exemption form, please upload to our secure Patient Portal at *sxu.medicatconnect.com*.** Alternately, it can be dropped off at the Health Center or faxed to 773-298-3906.