Saint Xavier University Health Center

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

□ Novavax 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):

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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.