UCSB
STUDENT HEALTH
Compassion • Quality • Convenience

University of California **Medical Exemption Request Form**

Full Name of Student:_____

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.
(list only 1 vaccine per section)

Please check the appropriate box and list below:

☐ a)The applicable CDC contraindication to this vaccine*, or
☐ b)The applicable manufacturers 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: The expiration date of the exemption for this vaccine is: _____

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.
(list only 1 vaccine per section)

Please check the appropriate box and list below:

☐ a)The applicable CDC contraindication to this vaccine*, or
☐ b)The applicable manufacturers 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: The expiration date of the exemption for this vaccine is: _____

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.

(list only 1 vaccine per section)

Please check the appropriate box and list below:

- ☐ a)The applicable CDC contraindication to this vaccine*, or
- ☐ b)The applicable manufacturers 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: The expiration date of the exemption for this vaccine is: _____

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.

(list only 1 vaccine per section)

Please check the appropriate box and list below:

- ☐ a)The applicable CDC contraindication to this vaccine*, or
- ☐ b)The applicable manufacturers 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: The expiration date of the exemption for this vaccine is: _____

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.
  (list only 1 vaccine per section)

  Please check the appropriate box and list below:

- ☐ a)The applicable CDC contraindication to this vaccine*, or
- ☐ b)The applicable manufacturers 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: The expiration date of the exemption for this vaccine is: _____

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 Medical 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:	Campus: _____
☐ Date Approved:_____	Address_____
☐ Date Denied:_____	_____
☐ Date of Entry into PnC:_____	_____