University of California **Medical Exemption Request Form**

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Full Name: _____

SID/Employee ID: _____

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 person has a medical condition that contraindicates his/her vaccination with the following vaccine(s):

For STUDENTS:

- ☐ MMR (Measles, Mumps, and Rubella)
- ☐ Meningococcal conjugate
- ☐ Tdap/DTaP
- ☐ Varicella
- ☐ COVID-19 (SARS-CoV-2)
- ☐ Influenza
- ☐ Other: _____

Please check the appropriate box and list below either:

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* **May not be accepted for COVID-19 vaccine, per UCOP policy**

*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: _____

_____ _____

Signature of Licensed Healthcare Provider Date

Office Stamp (REQUIRED)

_____ _____

Printed name of Healthcare Provider MD/DO/PA/NP

Medical License Number: _____

Once this form is filled out completely and signed by a healthcare provider, please upload to your campus' student health Patient Portal.