Creighton UNIVERSITY
Division of Student Life
Student Health Education and Compliance

Student Medical Exemption Request

Name (last name, first name) ______________________________

Net ID ______________________________

Mobile Phone ______________________________

Please check:

☐ I am requesting a medical exemption from the University's immunization requirement. (If selected, please sign and date and provide this form to your medical provider to complete the Provider Statement section below.)

Student Signature ______________________________ Date ______________

Provider Statement

The physical condition of the above named student is such that immunization would endanger life or health. Please select one of the two options below:

☐ This is a temporary exemption (e.g. pregnancy). For the following immunization(s):
______________________________ Expiration Date: ______________

☐ This is a permanent exemption (e.g. chronic illness, allergy) for the following immunization(s):
____

Explanation of chronic illness/reaction:

____

____

____

____
Provider signature (MD, NP, PA) Print Name Date

____
Address, City, State, Zip Phone