

MEDICAL EXEMPTION REQUEST

I request a medical exemption from the University's influenza requirement.

Name (last name, first name): _____

NetID: _____

Mobile Phone: _____

- I am a student requesting a medical exemption
 I am a faculty/staff/administrator requesting a medical exemption

Signature

Date

PROVIDER STATEMENT

The physical condition of the above-named individual is such that immunization would endanger life or health.

- This is a temporary exemption (e.g. pregnancy). Expiration date: _____
 This is a permanent exemption (e.g. chronic illness, allergy)

Explanation of chronic illness/reaction: _____

Provider signature (MD, NP, PA)

Print Name

Date

Address, City, State, Zip

Phone