SEATTLE UNIVERSITY
STATEMENT OF MEDICAL EXEMPTION TO IMMUNIZATION

Student Name _____

Date of Birth_____/_____/_____ SU ID # _____
Month Day Year

PART 1: TO BE COMPLETED AND SIGNED BY STUDENT (**and** parent/legal guardian if under 18 years old)

I have a medical reason (contraindication or precaution) why I am unable to receive the required vaccinations. If there is an outbreak of a vaccine-preventable disease that I have not been immunized against, or I am exposed to a vaccine-preventable disease that I have not been immunized against, I can be excluded from school until the outbreak or recommended quarantine/isolation period is over. I may also be subject to regular testing for certain vaccine-preventable diseases against which I have not been immunized. I am medically exempted from the following vaccine(s).

☐ Measles ☐ COVID-19 ☐ Other: _____

_____ _____
Student's Signature Date signed

(If under 18 years old)
Name of Parent/Guardian _____

_____ _____
Parent/Guardian's Signature Date signed

PART 2: TO BE COMPLETED BY HEALTHCARE PRACTITIONER (MD, DO, ARNP, PA and not a relative)
Medical contraindications and precautions for immunizations are based on the most recent General Recommendations of the Advisory Committee on Immunization Practices (ACIP)/CDC, available at Vaccine Recommendations and guidelines of the ACIP and Interim Clinical Considerations for Use of COVID-19 Vaccines Currently Authorized in the US. Please check the website to ensure that you are reviewing the most recent CDC/ACIP information.

Vaccine	Medical Contraindication/Precaution	Permanent Exempt	Temporary Exempt	Expiration date of temporary exemption
☐ MMR		☐	☐	
☐ COVID-19		☐	☐	
☐ _____		☐	☐	

By signing below, I affirm that I have reviewed the current CDC/ACIP Contraindications and Precautions, and the student listed above should be exempted from receiving the vaccine indicated. I declare that the information I provided is complete and correct, I understand that I might be required to submit supporting medical documentation.

_____ _____
Licensed Healthcare Practitioner Name (print) Phone number

_____ _____
Licensed Health Care Practitioner Signature Date

MD DO ARNP PA _____ _____
License number State