MEDICAL EXEMPTION REQUEST FORM

Student Name: ____________________________   Student ID #:________________________

Student Date of Birth: ____________________   Date: ________________

I, ____________________________ (Name of licensed MD, DO, PA NP) have reviewed the
California State University, Chico Immunization Exemption Policy, and hereby certify that the above-
name student has:

☐ A medical condition that contraindicates his/her vaccination with _____________________ vaccine:
Please select the appropriate box and list below either: (list only 1 vaccine per section)
a) ☐ The applicable CDC contraindicates to this vaccine,* or
b) ☐ The applicable manufacturer’s vaccine insert contraindication to this vaccine,* or
   ☐ 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, expiration date of the exemption for this vaccine is:

☐ 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:
Please select the appropriate box and list below either: (list only 1 vaccine per section)
a) ☐ The applicable CDC contraindicates to this vaccine,* or
b) ☐ The applicable manufacturer’s vaccine insert contraindication to this vaccine,* or
   ☐ 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, expiration date of the exemption for this vaccine is:

☐ Indicate that he/she is immune   ☐ Indicate he/she is NOT immune   ☐ Have not yet been obtained

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A medical condition that contraindicates his/her vaccination with ___________________________ vaccine:
Please select the appropriate box and list below either:
(list only 1 vaccine per section)
- a) ☐ The applicable CDC contraindicates to this vaccine,* or
- b) ☐ The applicable manufacturer’s vaccine insert contraindication to this vaccine,* or
  - ☐ 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, expiration date of the exemption for this vaccine is:

Titors 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

______
Students: Upload completed form to your WellCat Health Center Patient Portal

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