Habif Health and Wellness Center

STUDENT AFFAIRS AT WASHINGTON UNIVERSITY

Medical Immunization Exemption Form

<table>
<tr><td colspan="3">NOTE THAT MMR and MENINGITIS VACCINATION IS REQUIRED UNDER MISSOURI STATE IMMUNIZATION LAWS (Section 167.181 RSMo) FOR SCHOOL ATTENDANCE.</td></tr>
<tr><td>THIS IS TO CERTIFY THAT</td><td colspan="2">NAME OF STUDENT (PRINT)</td></tr>
<tr><td colspan="3">SHOULD BE EXEMPTED FROM THE FOLLOWING IMMUNIZATION(S)

☐ MMR (Measles, Mumps, and Rubella ☐ Meningitis ☐ Other

1. Unimmunized students have a greater risk of getting these vaccine preventable diseases which can lead to serious complications.
2. Unimmunized students are subject to be asked to leave school when outbreaks of vaccine-preventable diseases occur.</td></tr>
<tr><td colspan="3">Please have your medical provider complete page 2 of this form.</td></tr>
<tr><td>STUDENT NAME</td><td>STUDENT ID NUMBER</td><td>DOB</td></tr>
<tr><td>STUDENT SIGNATURE (PARENT/GUARDIAN IF STUDENT IS UNDER 18)</td><td colspan="2">DATE</td></tr>
</table>

Section I: To be completed by student or guardian (if student is under 18)

Last Name	First Name	Middle Initial	Date of Birth	Student ID#

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Section II: To be completed by medical provider only

Vaccine	Check all contraindications that apply to this patient below:
MMR	○ Severe allergic reaction (e.g. anaphylaxis) after a previous dose or to a vaccine component ○ Severe immunodeficiency (e.g chemotherapy, congenital immunodeficiency or long term immunosuppressive therapy, or persons with HIV infection who are severely immunocompromised ○ Family history of congenital or hereditary immunodeficiency in first-degree relatives unless the immune competence of the potential vaccine receipient has been verified clinically or by a laboratory test ○ Pregnancy
Meningitis ACWY	○ Severe allergic reaction (e.g. anaphylaxis) after a previous dose or to a vaccine component, including yeast

Documented allergy to a component of the vaccine-does not include sore arm, local reaction, or subsequent respiratory tract infection. Describe the specific reaction:

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Other documented contraindication: Please Explain***: Information to be reviewed by Infectious disease consultants for approval.***

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Medical Provider's Name:	Phone:
Address:	
Medical Provider's Signature:	Date:

Once completed, students should email a copy of the signed form to: studentimmunizations@wustl.edu .