



Medical Immunization Exemption Form

NOTE THAT MMR and MENINGITIS VACCINATION IS REQUIRED UNDER MISSOURI STATE IMMUNIZATION LAWS (Section 167.181 RSMo) FOR SCHOOL ATTENDANCE.		
<u>THIS IS TO CERTIFY THAT</u>	<u>NAME OF STUDENT (PRINT)</u>	
<u>SHOULD BE EXEMPTED FROM THE FOLLOWING IMMUNIZATION(S)</u>		
<input type="checkbox"/> MMR (Measles, Mumps, and Rubella) <input type="checkbox"/> Meningitis <input type="checkbox"/> Other		
<ol style="list-style-type: none"> 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. 		
Please have your medical provider complete page 2 of this form.		
<u>STUDENT NAME</u>	<u>STUDENT ID NUMBER</u>	<u>DOB</u>
<u>STUDENT SIGNATURE (PARENT/GUARDIAN IF STUDENT IS UNDER 18)</u>	<u>DATE</u>	

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#



Section II: To be completed by medical provider only

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

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

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 .