

STUDENT MUST COMPLETE	Name: _____		
	Please Print	(Last)	(First)
			(MI)
	Social Security Number _____ - _____ - _____		
	Date of Birth: _____		
	Month	Date	Year

PHYSICIAN COMPLETES	PHYSICIAN OR OTHER HEALTH CARE PROVIDER VERIFICATION: (See other side)				
	Measles (Rubeola)	Rubella	Mumps	Tetanus - Diphtheria	Menigitis
	1st Immunization: _____ (Date)	Immunization: _____ (Date)	Immunization: _____ (Date)	Immunization: _____ (Date within 10 yrs.)	Immunization: _____ (Date within 10 yrs.)
	and 2nd Immunization: _____ (Date)	or Serologic Test: _____ (Date)	or Date of Disease: _____ (Date)	or	or Serologic Test: _____ (Date)
	or Date of Disease: _____ (Date)	and Result: _____ (Date)	or Serologic Test: _____ (Date and Result)		or Result: _____ (Date)
	or Serologic Test: _____ (Date and Results)				
_____ (Signature of Physician or Other Health Care Provider)		_____ (Date)	<i>(Please Place Address or Stamp Above)</i>		

WAIVER OF MENINGITIS VACCINATION AND RELEASE FROM RESPONSIBILITY:

I HAVE BEEN FULLY INFORMED BY READING THE CENTERS FOR DISEASE CONTROL AND PREVENTION MENINGITIS VACCINE INFORMATION STATEMENT AND UNDERSTAND THE POSSIBLE AND PROBABLE ADVERSE CONSEQUENCES. I UNDERSTAND THAT MY HEALTH COULD BE NEGATIVELY AFFECTED AND MY LIFE POSSIBLY ENDANGERED BY NOT RECEIVING THE VACCINE.

The reason for not being vaccinated is:

Personal Unavailability of the Vaccine (I have provided a statement verifying that I have tried to receive the vaccine but could not find any.)

I am an online student and will not be on the campus for courses Medical Religious

I declare myself to be a person of the full age of majority and to be mentally competent. I hereby assume full responsibility for any and all possible present or future results or complications of my condition due to this refusal.

I do further hereby now and forever free and release the University and the Department of Health and Hospitals and all its agents, attending health care professionals, and other personnel from any and all legal or financial responsibility as a result of this refusal.

I certify that I have read (or had read to me) and that I fully understand this release from Responsibility. All explanations were made to me and all blanks filled in before I signed my name.

Month	Day	Year	Time	Printed Name	Signature
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REQUEST FOR EXEMPTION FOR MEASLES, MUMPS, RUBELLA AND TETANUS-DIPHTERIA:

If you request exemption for medical or personal reasons, please check the appropriate box and provide the information requested.

1. Medical reasons: (Physician's statement—use space below) 2. Personal reasons: (State reason in space provided)

I understand that if I claim exemption for personal or medical reasons, I may be excluded from campus and from classes in the event of an outbreak of measles, mumps, or rubella until the outbreak is over or until I submit proof of immunization. If I am not 18 years of age, my parent or legal guardian must sign below.

_____ (Student's Signature)	_____ (Date)	_____ (Parent or Gaurdian, if required)	_____ (Date)
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