



## IMMUNIZATION EXEMPTION REQUEST - MEDICAL

### STUDENT INFORMATION

Legal Name: \_\_\_\_\_ RED ID: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone Number: \_\_\_\_\_

### EXEMPTION REQUEST PROCESS

In the interest of maintaining the health and safety of students, employees, guests and all members of campus communities, and in accordance with the California State University Policy (EO 803) on immunization requirements, San Diego State University has implemented immunization requirements. These are conditions of enrollment for all students in undergraduate programs as well as graduate and doctoral programs classified as in-person or hybrid programs.

In accordance with this policy, SDSU students may seek an exemption for medical concerns or due to sincerely held religious beliefs. This process is only required one time. Students will not need to re-submit annually.

Please complete this form in its entirety and submit your completed acknowledgments via the Upload tab on HealtheConnect. Our team will review your submission and respond within 5 business days.

### EXEMPTIONS BEING REQUESTED

I am requesting a medical exemption for the following immunization(s):

- Measles, Mumps, Rubella (MMR)
- Hepatitis B
- Varicella (Chickenpox)
- Tetanus, Diphtheria, Pertussis (Tdap)
- Meningococcal conjugate (Serogroups A, C, Y, W-135)
- Meningococcal B

### ACKNOWLEDGMENTS

Please initial each of the acknowledgments below.

\_\_\_\_\_ I understand that medical exemptions may be requested due to a medical (including mental health) condition for which an approved vaccine presents a significant risk of a serious adverse reaction. Any medical exemption must be verified by a certified or licensed healthcare professional.

\_\_\_\_\_Based on the above, I certify that I qualify for a medical exemption and have not completed the vaccine series indicated, nor do I plan to.

\_\_\_\_\_I understand that I may be expected to provide supporting documentation to this effect immediately upon request. Supporting documentation is documentation from a certified or licensed healthcare professional that describes the medical (including mental health) condition which is the basis for the exemption.

\_\_\_\_\_I understand that unvaccinated persons may be at increased risk of developing any of the conditions for which immunizations are required, if exposed to any of these diseases. Information on each of the vaccine-preventable diseases that these immunizations help to prevent or reduce severity is available here: <https://www.cdc.gov/vaccines/vpd/vaccines-diseases.html>.

\_\_\_\_\_I understand that, for the protection of myself and other community members, I may be excluded from attending classes or in-person University activities for prolonged periods during outbreaks or as a result of exposure to any one of these diseases.

\_\_\_\_\_I understand that I may be required to take additional health measures by the university or the local health authority based on my immunization status. This may include, but is not limited to wearing additional personal protective equipment, such as facial coverings, regular testing, or modification of participation in University activities.

\_\_\_\_\_I also understand that SDSU may change its vaccination policy in the future and require additional measures for those who are unvaccinated.

\_\_\_\_\_I may change my mind at any time and submit documentation of a completed vaccination series and nullify this exemption.

## ATTESTATION

I confirm that the information I have provided is accurate and truthful to the best of my knowledge. I also understand that violations of this policy, including dishonesty may be subject to consequences under the Student Conduct Code, as outlined in procedures in CSU Executive Order 1098, Student Conduct Procedures or employee discipline pursuant to California Education Code Section 89535.

\_\_\_\_\_  
(Student Signature)

\_\_\_\_\_  
(Date)



**MEDICAL PROVIDER CERTIFICATION**

Form must be completed by a licensed Physician (MD/DO), Nurse Practitioner, or Physician's Assistant.

I certify that the patient has a physical condition or medical circumstance such that immunization otherwise required for enrollment at San Diego State University is not considered safe. I understand that, for the protection of the patient and other students, the patient may be excluded from attending school for prolonged periods during outbreaks or exposure to disease for which immunization has not been completed.

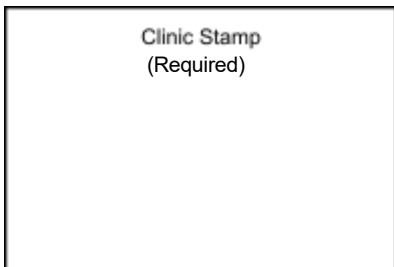
Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Immunizations Included in Exemption:

Immunization	Duration of physical condition or medical circumstance	
<input type="checkbox"/> Measles, Mumps, Rubella (MMR)	<input type="checkbox"/> Permanent	<input type="checkbox"/> Temporary until date: _____
<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Permanent	<input type="checkbox"/> Temporary until date: _____
<input type="checkbox"/> Varicella	<input type="checkbox"/> Permanent	<input type="checkbox"/> Temporary until date: _____
<input type="checkbox"/> Tetanus, Diphtheria, Pertussis (Tdap)	<input type="checkbox"/> Permanent	<input type="checkbox"/> Temporary until date: _____
<input type="checkbox"/> Meningococcal conjugate (Serogroups A, C, Y, W-135)	<input type="checkbox"/> Permanent	<input type="checkbox"/> Temporary until date: _____
<input type="checkbox"/> Meningococcal B	<input type="checkbox"/> Permanent	<input type="checkbox"/> Temporary until date: _____

Comments or additional information (required):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



Provider Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

License Number: \_\_\_\_\_

Date: \_\_\_\_\_