UNIVERSITY OF CALIFORNIA, RIVERSIDE

BERKELEY ● DAVIS ● IRVINE ● MERCED ● LOS ANGELES ● RIVERSIDE ● SAN DIEGO ● SAN FRANCISCO

SANTA BARBARA ● SANTA CRUZ

STUDENT HEALTH SERVICES

Vaccination Medical Exemption Request Form

Name of Student: _____
Student's University ID Number: _____
Student's Date of Birth: _____

I,_____[Name of licensed MD, DO, PA, NP] certify that the patient named above has:

1) A medical condition that contraindicates his/her vaccination with_____[Name of vaccine].

   This name of the condition/diagnosis is: _____

   The type of contraindicating vaccine is: _____

   This condition/diagnosis is:

   - ☐ Permanent
   - ☐ Temporary:_____[name of vaccine] may be given in_____[number of months]

OR

2) The patient experienced a severe adverse reaction, specifically:

   _____

   _____ [description of reaction] when he/she received a prior dose.

3) Titers for immunity to this disease:

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

Signature of Healthcare Provider:	Date:	Medical License Number & State/Country of Issue:
Practice Address:		Provider Phone Number and Email:

Return this completed form to Student Health Service at UC Riverside Campus in person, or by faxing to 951-827-3133.

6/15/16 bw