
MEDICAL EXEMPTION REQUEST FORM

Full Name of Student: _____ **Date of Birth:** _____

Bronco ID: _____ **Phone #:** _____

I, _____ (Print name of licensed, board certified MD, DO, PA, NP) have reviewed the CSU immunization requirements and hereby certify that the above-named student has a medical condition that contraindicates their vaccination with the following vaccines(s):

MMR Tdap (Pertussis) Meningitis Varicella (chicken pox) Hepatitis B

The physical condition of the person, or medical circumstances relating to the person, are such that immunization is not considered safe. The specific nature of the medical condition or circumstances that contraindicates immunization with this vaccines(s) are indicated below.

REQUIRED - Description of contraindications:

This contraindication is Permanent or Temporary

If temporary: The expiration date of the exemption for this vaccine is: _____

| |
|---------------------|
| Clinic Stamp |
|---------------------|

Medical Provider Signature: _____

Printed Name: _____

License Number: _____

Date: _____

Disclaimer: Medical exemptions are evaluated on a case by case basis. Medical records may be requested by SHS for review prior to granting a medical exemption.

In active infectious disease outbreak situations, I, _____
(Print Student Name), may not be allowed to come to campus or I may have to leave the residence halls. I understand these situations will be determined on a case by case basis, and in consultation with state and local public health officials.

Student Signature: _____ **Date:** _____

Students: Please upload as Immunization Record by using the My Health Portal:
<https://myhealthportal.cpp.edu/clearances.aspx>.

Revision 6/2020