University of California **Medical Exemption Request Form**

BERKELEY • DAVIS • IRVINE • LOS ANGELES • MERCED • RIVERSIDE • SAN DIEGO • SAN FRANCISCO • SANTA BARBARA • SANTA CRUZ

Full Name: _____

SID/Employee ID: _____

Date of Birth: _____

I, _____ [Name of licensed MD, DO, PA, NP] have reviewed the University of California Immunization Exemption Policy, and hereby certify that:

The above-named person has a medical condition or contraindication to receiving the following vaccine(s):

For STUDENTS: ☐ MMR ☐ Meningococcal conjugate ☐ Tdap/DTaP ☐ Varicella ☐ Other

Please check the appropriate box and list below either

A) ☐ The applicable contraindications or precautions are recognized by the CDC, CDPH, or in the case of internationally administered vaccines, WHO.

B) ☐ The applicable manufacturer's vaccine insert contraindication to this vaccine*, or

C) ☐ The physical condition of the person or medical circumstances relating to the person that are such that immunization is not considered safe, indicating the specific nature of the medical condition or circumstances* that contraindicate immunization with this vaccine*

*REQUIRED: **Description of contraindication:**

_____

_____

_____

_____

_____

This contraindication is: ☐ Permanent or ☐ Temporary: Expiration date of exemption _____

_____
Signature of Licensed Healthcare Provider

_____
Date

Office Stamp
(REQUIRED)

_____
Printed name of Healthcare Provider

_____
MD/DO/PA/NP

Medical License Number*: _____

Once this form is filled out completely and signed by a healthcare provider, please upload to your campus' student health Patient Portal.

*Required