**EXEMPTION FROM IMMUNIZATIONS DECLARATION**

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

Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Enrollment Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I am requesting an exemption from one or more of the following vaccinations and I am aware of the risks (check all that apply):**

 **□ MMR 1st dose □ MMR 2nd dose □ TETANUS □ MENINGITIS**

 **□ COVID-19 1st dose □ COVID-19 2nd dose**

**Reason for exemption for the above-referenced immunization(s):**

**□ Medical - If a medical exemption is declared, Student must return the completed Vaccine Exemption Physician**

 **Certification Form (attached).**

**□ Personal/Philosophical - If this exemption is requested, state the reason: f**

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that apply):

□ MMR 1st dose □ MMR 2nd dose □ TETANUS □ MENINGITIS

□ COVID-19 1st dose □ COVID-19 2nd dose

Reason for exemption for the above-referenced immunization(s):

□ Medical - If a medical exemption is declared, Student must return the completed Vaccine Exemption Physician

Certification Form (attached) to Student Health Services at Patient Portal at ull.medicatconnect.com.

□ Personal/Philosophical - If this exemption is requested, state the reason:

**Understand the Risks and Responsibilities**

Pursuant to Louisiana R.S. § 17:170: In the event of an outbreak of a vaccine-preventable disease at Infinity College the administrators are empowered, upon the recommendation of the Louisiana Office of Public Health, to exclude from attendance unimmunized students until the appropriate disease incubation period has expired or the unimmunized person presents evidence of immunization.

By signing below, I understand that if I declare an exemption, I may be excluded from campus and from classes in the event of an outbreak until the outbreak is over or until I submit proof of immunizations. I understand that if I decline any of the required vaccinations, I continue to be at risk for serious disease. I can always receive the vaccine(s) at any time. I have read and understand the vaccine information from the Louisiana Office of Public Health and the Centers for Disease Control and Prevention and understand risks and responsibilities in exempting/declining the required immunizations.

**Student Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

If student is not 18 years of age, legal guardian must sign below.

**Parent or Guardian Signature (if required): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Vaccine Exemption Physician Certification**

I am a physician licensed to practice medicine in a jurisdiction of the United States. By signing below, I certify that for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (patient name), the following vaccine(s) is(are) contraindicated for medical reasons (check all that apply):

**□ MMR 1st dose □ MMR 2nd dose □ TETANUS □ MENINGITIS**

**□ COVID-19 1st dose □ COVID-19 2nd dose**

The contraindication(s) is(are): □ Permanent □ Temporary

If temporary, the contraindication is expected to preclude immunizations until: Date \_\_\_\_\_\_\_\_\_\_

**Physician Information**

Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Specialty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Name of Physician Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_