Goodwin University

BMEI

Modifed: May 23, 2023 3:36 PM

Appendix B - Request for Medical Exemption From Immunization/s

STUDENT INFORMATION

Full Name: _____
Last First

Student ID Number: _____ **Birthdate:** ___/___/___
MM/DD/YYYY

Full Address: _____
City State Zipcode

Email: _____ **Phone:** _____

I AM REQUESTING A MEDICAL EXEMPTION FROM THE FOLLOWING IMMUNIZATIONS:

(Check all that apply)

☐ Measles ☐ Mumps ☐ Rubella ☐ Varicella ☐ Meningococcal

If you are requesting an exemption from any immunization for a medical reason, please select from the options below and provide the requested supporting medical documentation as indicated.

☐ I am requesting a medical exemption because the immunization/s as indicated above is/are medically contraindicated. I will provide documentation from a medical physician or advanced practice registered nurse (APRN) that such immunization is medically contraindicated.

☐ I am requesting a medical exemption because I have had a confirmed case of the disease/s indicated above. I will provide medical documentation from a medical physician or APRN, or the director of health of my current or former town of residence indicating that I had a confirmed case of the respective disease or I will provide documentation of a titer test.

I UNDERSTAND AND AGREE TO THE FOLLOWING IF MY EXEMPTION IS ACCEPTED:

That by filing for an exemption to the Immunization Policy, I will not be allowed on campus in the event of an outbreak for the duration of the outbreak for a disease that I am not immunized for as required by law and indicated in my records, and I will accept any of the associated consequences.

That should I be exposed to a disease for which I am not immunized for as required by law and indicated in my records, I agree to notify the University and understand that I will not be allowed on campus until it has been determined that it is medically safe for me and the University Community, and I will accept any of the associated consequences.

_____ _____
Signature of Student Date

_____ _____
Signature of Parent or Guardian if Student is under the age of 18 years Date

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THIS SECTION IS TO BE FILLED OUT BY THE MEDICAL PHYSICIAN OR ADVANCED PRACTICE REGISTERED NURSE (APRN)

I certify that the above information is correct according to the above student's medical records.

_____ _____
Print name of medical physician or APRN Date

_____ _____
Signature of medical physician or APRN Medical physician/APRN contact email or phone number