Illinois State University - Student Medical Exemption Request for Required Immunizations

Name of Primary Care Provider Requesting Exemption _____

Above named provider is licensed as the following:

- ○ **Physician (MD or DO)**
- ○ **Advanced Practice Registered Nurse (APRN)**
- ○ **Physician Assistant**

Student Name: _____

Student UID #: _____

Date of Birth (MM/DD/YYYY): _____

Medical Exemption Request is:

- ○ **Permanent**
- ○ **Temporary – through _____/_____/_____**

Please mark any that are part of this request:

- ○ **TD**
- ○ **Tdap**
- ○ **Measles**
- ○ **Mumps**
- ○ **Rubella**
- ○ **Meningococcal conjugate vaccines (Men ACWY)**

Justification for request, based on CDC Recognized Contraindications and Precautions

_____ _____

Medical Provider Signature **Date** *Office Stamp*