



**Immunization Exemption Form**

Healthcare workers (HCWs) are at risk for exposure to serious, and sometimes deadly, diseases. If you work directly with patients or handle material that could spread infection, you should get appropriate vaccines to reduce the chance that you will get or spread vaccine-preventable diseases. Protect yourself, your patients, and your family members. Make sure you are up-to-date with recommended vaccines. Healthcare workers include physicians, nurses, emergency medical personnel, dental professionals and students, medical and nursing students, laboratory technicians, pharmacists, hospital volunteers, and administrative staff. Source: Centers for Disease Control and Prevention.  
<https://www.cdc.gov/vaccines/adults/rec-vac/hcw.html>

I understand that as a student in the nursing program, I will be exposed to infectious materials and run the risk of contracting disease. I understand that if I request an exemption, I may not be able to attend a clinical experience based on the clinical agency’s policy and may not be able to complete the clinical requirements in the nursing program. I also understand that I will accept any academic or health consequences resulting in my decision.

***I request an exemption from the following immunizations(s) for the following purpose:  
 (document the immunization requested, check the reason category and explain reasoning)***

Immunization Requested for Waiver	Medical	Religious	Explanation for Waiver
Immunization: _____			
Immunization: _____			
Immunization: _____			
Immunization: _____			
Immunization: _____			

Print Name of Person Requesting the Immunization Exemption: \_\_\_\_\_

Signature of Person Requesting the Exemption: \_\_\_\_\_ Date: \_\_\_\_\_

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Print Name of Physician for Medical Waiver: \_\_\_\_\_

Signature of Physician for Medical Waiver: \_\_\_\_\_ Date: \_\_\_\_\_

Address of practice: \_\_\_\_\_  
 \_\_\_\_\_

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Print Name of Religious Representative for Religious Exemption: \_\_\_\_\_

Signature of Religious Representative: \_\_\_\_\_

Contact information: