

Medical Exemption to the Immunization Requirement Physician Form

Student to complete.

Student's Name: Last		First		UID#
Date of Birth	Age	University email address	Phone	
Street Address			City	State Zip Code

Physician to complete.

_____ should be granted a permanent or temporary (____ days) exemption
 (Student name)
 from the immunization requirement for (check all that apply) MMR PPD/TB(Tuberculosis) Tetanus Toxoid
 because:

- | | |
|---|--|
| <input type="checkbox"/> Patient is pregnant | <input type="checkbox"/> Patient is currently ill |
| <input type="checkbox"/> Patient is breast-feeding | <input type="checkbox"/> Patient is on medications that contraindicate the injection |
| <input type="checkbox"/> Patient has recently been immunized | <input type="checkbox"/> Patient has had a severe anaphylactic reaction to eggs |
| <input type="checkbox"/> Patient has a temperature above 100 degrees F° | <input type="checkbox"/> Other (Please explain below) |

An official stamp from a physician's office, clinic, or health department AND an authorized signature must appear below or this form WILL NOT be accepted

Official office stamp

 Physician or Authorized Signature

 Date

Please submit this completed form to:
 Florida Polytechnic University, Office of Admissions 4700 Research Way, Lakeland,
 FL 33805, OR e-mail to immunizations@floridapoly.edu



Religious Exemption to the Immunization Requirement Request

Please check the basis for your religious exemption (Check only one)

- I certify that I am a member of an organized religious group whose tenets and/or practices prohibit me from receiving medical vaccinations.
- I certify that that I am not a member of an organized religious group, but that medical vaccinations do violate my personally held religious beliefs and/or practices.

Therefore, I request that I be enrolled without receiving the required immunizations. I understand the risks associated with failing to be immunized and request exemption from these requirements. I also understand that I may be excluded from attending classes or other activities for the duration of a vaccine preventable disease outbreak which can last up to 21 days after the last case is detected at the University.

I agree that I am completely responsible for any costs associated with my exclusion from classes or University activities. I am aware that failure to receive medically recommended or required vaccinations may increase my risk of acquiring a preventable infectious disease, and I am willing to accept such medical risk.

Student Name

UID Number

Student Signature

Date

Parent/Guardian Signature (if under 18)

University email address

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