Florida Polytechnic University
Health Clinic
(863)874-8672 phone
immunizations@flpoly.org

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:

☐ Patient is pregnant

☐ Patient is breast-feeding

☐ Patient has recently been immunized

☐ Patient has a temperature above 100 degrees F°

☐ Patient is currently ill

☐ Patient is on medications that contraindicate the injection

☐ Patient has had a severe anaphylactic reaction to eggs

☐ 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, Health Clinic, 4700 Research Way, Lakeland, FL 33805,
OR e-mail to immunizations@flpoly.org

8-7-2015

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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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