



Medical Exemption to the Immunization Requirement Physician Form

Student to complete.

Form with fields for 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 currently ill
[ ] Patient is breast-feeding [ ] Patient is on medications that contraindicate the injection
[ ] Patient has recently been immunized [ ] Patient has had a severe anaphylactic reaction to eggs
[ ] Patient has a temperature above 100 degrees F° [ ] Other (Please explain below)

Three horizontal lines for additional physician notes.

\*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 box

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

Please submit this completed form to:  
Florida Polytechnic University, Office of Admissions, 4700 Research Way, Lakeland,  
FL 33805 OR email to [immunizations@floridapoly.edu](mailto:immunizations@floridapoly.edu)