



Immunization Waiver

Please be aware that in the case of an outbreak of a specific disease for which you have waived immunization, it is plausible that the Public Health Department could mandate quarantine, thereby preventing a non-immunized student from accessing the campus.

Name _____
Last First Middle

Home Address _____
City State ZIP

Email _____

Home Phone (____) ____ - ____ Cell (____) ____ - ____

Date of Birth ____/____/____ Gender [] Male [] Female

Medical Exemptions

The physical condition of the above individual is such that immunization would endanger life or health.

Please explain:

Physician Signature _____ Date ____/____/____

Personal Exemptions

I take full responsibility in the event of any possible illness or injury resulting from waiving or delaying my immunization requirement.

Please explain:

Please check any applicable immunizations:

- [] Measles/Mumps/Rubella (MMR)
[] Hepatitis B
[] Tetanus Diptheria (Tdap)
[] Varicella (chicken pox)
[] Influenza
[] Other: _____

Please note that the TB Test cannot be waived.

Student's Signature _____ Date ____/____/____

Parent/Legal Guardian Signature _____ Date ____/____/____
(If student is under 18 years of age)