Request for a WAIVER from the Immunization Requirement

Student Information

Name: _____

Student # _____

Current Mailing Address: _____
Address City State Zip Code

Email Address: _____

Date of Birth: _____ Current Phone _____

Reason for your request:

☐ **Medical** ☐ **Religious**

Student Signature: _____ **Date:** _____

Health Care Provider Documentation

I certify that I have explained the risks of foregoing immunizations to this student or I certify that this student has legitimate medical reasons for inadequate immunity because (state reason below):

_____

_____

_____ _____
Health Care Provider's Signature/Title/Date Print Name and Title

Address: _____ Telephone: _____

_____

Upload this completed form to your Med+Proctor student account.