University of California **Medical Exemption Request Form**

BERKELEY • DAVIS • IRVINE • LOS ANGELES • MERCED • RIVERSIDE • SAN DIEGO • SAN FRANCISCO • SANTA BARBARA • SANTA CRUZ

Full Student Name: _____

Date of Birth: _____

Email: _____

I, _____ [Name of licensed MD, DO, PA, NP] have reviewed the University of California Immunization Exemption Policy, [**https://www.ucop.edu/uc-health/_files/UC%20Immunization%20Exemption%20Policy.pdf**] and hereby certify that:

The above-named person has a medical condition that contraindicates his/her/their vaccination with the following vaccine(s):

For STUDENT

- ☐ MMR (Measles, Mumps, and Rubella)
- ☐ Meningococcal conjugate
- ☐ Tdap/DTaP
- ☐ Varicella
- ☐ COVID-19 (SARS-CoV-2)
- ☐ Influenza
- ☐ Other: _____

Please check the appropriate box and list below either:

a) ☐ The applicable CDC contraindication to this vaccine*, or

b) ☐ The applicable manufacturer's vaccine insert contraindication to this vaccine*, or

c) ☐ The physical condition of the person or medical circumstances relating to the person that are such that immunization is not considered safe, indicating the specific nature of the medical condition or circumstances* that contraindicate immunization with this vaccine* **May not be accepted for COVID-19 vaccine, per UCOP policy**

*REQUIRED: **Description of contraindication meeting criteria a, b, or c above:**

_____

_____

_____

_____

This contraindication is: ☐ Permanent or ☐ Temporary

If temporary: The expiration date of the exemption for this vaccine is: _____

_____ _____

Signature of Licensed Healthcare Provider Date

Office Stamp (REQUIRED)

_____ _____

Printed name of Healthcare Provider MD/DO/PA/NP

Medical License Number: _____