Request for a WAIVER from the Immunization Requirement

Student Information

Name: _____

Student ID#: _____

Current Mailing Address: _____
Address City State Zip Code

Email Address: _____

Date of Birth: _____ Current Phone: _____

I. Identify the category of your request (circle applicable reason):

Medical *(requires physicians' signature)* **Religious** **Online Program Only**

2. Please describe the reason for your request in the space below:

Student Signature:_____ **Date:** _____

Health Care Provider Documentation (*required for medical waiver request***):**

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

Current Mailing Address: _____
Address City State Zip Code

Telephone: _____

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