Student Health Services
Exemption For Influenza Vaccination

Student Name (Last, First, Middle)	Gender ☐M ☐F	Date of Birth __ __ / __ __ / __ __ __ __ Month/ Day / Year	Telephone Number
Parent/Guardian Name (if student is under 18 years old)		Address:	
Student Email:		Student University ID (if available):	

A. LOYOLA MARYMOUNT UNIVERSITY (LMU) STUDENT HEALTH SERVICES (SHS) POLICY

By the order of the LA County Department of Public Health, all students who have reason to be on campus are required to be immunized against seasonal influenza. **Students can be exempt only if they have a medical contraindication to the vaccine. LMU adheres to the Advisory Committee on Immunization Practices (ACIP) guidelines for vaccine exemptions.***

B. AUTHORIZED HEALTH CARE PROVIDER (HCP)** – FILL OUT THIS SECTION

I am a (check one): ☐ MD/DO ☐ Nurse Practitioner ☐ Physician Assistant and I have reviewed the ACIP guidelines for influenza vaccine exemptions.

Permanent Exemption

☐History of severe allergic reaction to influenza vaccine or any of its components.
☐Immune deficiency due to (diagnosis): _____
☐Guillainn-Barre syndrome within 6 weeks of a previous dose of influenza vaccine.

Temporary Exemption

☐ Patient should not be vaccinated at this time because they currently have (diagnosis required): _____ but may be vaccinated on or after (date required):_____.

Health Care Provider's Name (please print) _____

License #: _____
Address: _____
Telephone number:_____

Practitioner Stamp (If available)

_____ Signature Of Authorized HCP

_____ Date (within 12 months prior to entry to University)

C. STUDENT OR PARENT/GUARDIAN (IF STUDENT IS UNDER 18 YEARS OLD)

Be advised, universities are centers of congregate living. By signing this you acknowledge that by being un-vaccinated poses an increased risk to yourself, and the university community at large, of becoming ill with seasonal influenza.

_____ Student Signature	_____ Date	_____ Parent/Guardian Signature (If student is under 18 years old)	_____ Date

* https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html

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** This form must be completed by a non-LMU health care provider.