Student Health Services
Exemption For Required Vaccinations

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

LMU SHS requires proof of two ***Measles/Mumps/Rubella (MMR) vaccines*** in the student's lifetime or a positive MMR titer indicating immunity to the diseases. **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

Indicate which medical condition(s) the student has, including family medical history, for which MMR vaccine is contraindicated:

☐Severe allergic reaction after a previous dose or to a vaccine component

☐Pregnancy

☐Known severe immunodeficiency (e.g., from hematologic and solid tumors, receipt of chemotherapy, congenital immunodeficiency, long-term immunosuppressive therapy, or patients with HIV infection who are severely immunocompromised)

☐Family history of congenital/hereditary immunodeficiency in first-degree relatives

Please select the type of medical exemption ☐ Permanent ☐ Temporary

If the exemption is temporary please indicate the expiration date of the exemption: _____

Health Care Provider's Name (please print) _____

License #: _____ Practitioner Stamp (If available)

Address: _____

Telephone number:_____

_____ _____

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**, an unvaccinated student is at greater risk of becoming ill with the vaccine-preventable disease. An unvaccinated student ***may*** be excluded from attending school during an outbreak of, or after exposure to, any of these diseases: ***Measles, Mumps, Rubella***

I am requesting a **medical** exemption to the ***Measles/Mumps/Rubella (MMR) vaccine.***

If the medical exemption is *temporary*, I will submit the proper documentation showing proof of required immunization once the medical exemption has expired.

_____	_____	_____	_____
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

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

Revised 10/14/20