# Student Health Services Exemption For Required Vaccinations

<table>
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<tr>
<th>STUDENT NAME (LAST, FIRST, MIDDLE)</th>
<th>Gender</th>
<th>Date of Birth</th>
<th>Telephone Number</th>
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<td>Month/Day/Year</td>
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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.**

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

I am a (check one):  
- ☐ MD/ DO  
- ☐ Nurse Practitioner  
- ☐ Physician Assistant

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

![Medical Condition(s)](image)

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 #: ____________________________  
Address: ____________________________  
Telephone number: ____________________________

Practitioner Stamp (If available)

Signature Of Authorized HCP.  
Date- within 12 month prior to entry to University

## C. STUDENT OR PARENT/GURDIAN (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.

<table>
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<tr>
<th>Student Signature</th>
<th>Date</th>
<th>Parent/Guardian Signature</th>
<th>Date</th>
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*This form must be completed by a non-LMU health care provider.*

Revise: 6/6/16