

**Student Health Services  
Exemption For Required Vaccinations**



STUDENT NAME (LAST, FIRST, MIDDLE)	Gender <input type="checkbox"/> M <input type="checkbox"/> 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 life time 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:

\_\_\_\_\_

\_\_\_\_\_

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 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.

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature  
(If student is under 18 years old)

\_\_\_\_\_  
Date

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