SHENANDOAH UNIVERSITY

Wilkins Wellness Center
Medical Exemption from Vaccinations Request - Student

Section I: (to be completed by Student or Parent/Guardian if Student is under 18)

Student Name: _____ Date of Birth: _____
First MI Last

Student ID Number: _____

Shenandoah University may grant a medical exemption from one or more of the vaccination or test requirements listed below to any Shenandoah student who makes a request, although students in any programs in the Nursing, Pharmacy or Health Professions schools, or in any other program that requires clinical or experiential training, including without limitation music therapy ("Clinical/Experiential Programs"), should be aware that if the University grants the student's request, it cannot guarantee the student will be able to secure the clinical/experiential assignments necessary to graduate with a degree, or to obtain a licensed position, in their field. In addition, Shenandoah may, in its discretion, make the student responsible for securing clinical/experiential assignments at clinical/experiential sites acceptable to their program.

I also understand and acknowledge that if the University approves my request for a medical exemption from its vaccination requirements, I will not have the protections afforded by the vaccine(s). By signing below, I knowingly and voluntarily agree to assume the risks associated with being a student at the University, and participating in University activities on and off campus, without the vaccine(s) intended to prevent the diseases or medical conditions listed below. In addition, I understand that in the event of an outbreak, potential epidemic or epidemic of a vaccine-preventable disease, the University or the State Health Commissioner or their designee may order my exclusion from the University (or restrict my University activities), for my own protection or the protection of others, until the danger has passed.

Student Signature: _____ Date: _____

If the student is under the age of 18, I _____ hereby represent that I am a parent or legal guardian of the student identified above, and I consent to their request for a medical exemption. In addition, I hereby acknowledge and confirm the representations made by the student herein.

Parent/Legal Guardian Signature: _____ Date: _____

Section II: (to be completed by Medical Provider who must be a licensed physician, physician's assistant or nurse practitioner)

The above-named student is requesting a medical exemption from one or more of the University's vaccination requirements. The University may approve such a request in the event immunization is contraindicated for one of the reasons described below. Please complete the form below. Should you have any questions, please contact the University's Wilkins Wellness Center at (540) 665-4530. Thank you.

Medical Provider Certification of Contraindication: I certify that my patient (student named above) should not receive the following vaccination(s) because they have one of the following contraindications (please check all that apply):

I. COVID-19

□ History of previous allergic reaction, or documented allergy testing to indicate an immediate hypersensitivity reaction, to the vaccine or a component of the vaccine.

□ Other contraindication (please explain): _____

II. MMR

□ History of previous allergic reaction, or documented allergy testing to indicate an immediate hypersensitivity reaction, to the vaccine or a component of the vaccine.

□ Other contraindication (please explain): _____

III. Polio

□ History of previous allergic reaction, or documented allergy testing to indicate an immediate hypersensitivity reaction, to the vaccine or a component of the vaccine.

□ Other contraindication (please explain): _____

IV. Adult TDAP

□ History of previous allergic reaction, or documented allergy testing to indicate an immediate hypersensitivity reaction, to the vaccine or a component of the vaccine.

□ Other contraindication (please explain): _____

V. Varicella (Only Required for Students in Health Care-Related Programs)

□ History of previous allergic reaction, or documented allergy testing to indicate an immediate hypersensitivity reaction, to the vaccine or a component of the vaccine.

□ Other contraindication (please explain): _____

VI. Meningitis

□ History of previous allergic reaction, or documented allergy testing to indicate an immediate hypersensitivity reaction, to the vaccine or a component of the vaccine.

□ Other contraindication (please explain): _____

VII. Hepatitis B

□ History of previous allergic reaction, or documented allergy testing to indicate an immediate hypersensitivity reaction, to the vaccine or a component of the vaccine.

□ Other contraindication (please explain): _____

VIII. Flu

□ History of previous allergic reaction, or documented allergy testing to indicate an immediate hypersensitivity reaction, to the vaccine or a component of the vaccine.

□ Other contraindication (please explain): _____

I understand that in the event of an outbreak, potential epidemic or epidemic of a vaccine-preventable disease, the University or the State Health Commissioner or their designee may order this student's exclusion from the University (or restrict the student's University activities), for their own protection and/or the protection of others, until the danger has passed.

Medical Provider Signature	Medical Provider License Number
Medical Provider Name (printed)	Date

Medical Provider Address (Street, City, State, ZIP Code)

VACCINATION EXEMPTION COMMITTEE DECISION:

APPROVED: ___ DENIED: ___

DATE: _____ TIME: _____