



# University of Lynchburg

## Medical Exemption Form for Immunizations

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Student ID: \_\_\_\_\_

### Part 1 Completed by Health Care Provider:

I certify that the administration of the vaccine(s) designated below would be detrimental to this student's health. Please provide information that describes the exemption basis in detail, including the nature and probable duration of the exemption. *Note: In order to comply with the Genetic Information Nondiscrimination Act of 2008 (GINA), the University asks that you not provide any genetic information about this individual or a family member of the individual when responding to this request for medical certification.* The person named above should not receive the indicated vaccines due to:

DTP/Dtap  Td/Tdap  Measles  Mumps  Rubella  Hepatitis B   
Varicella  Meningococcal  COVID-19

\_\_\_\_\_  
Medical Provider Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone

### Part 2 Completed by student and legal guardian if student under age 18:

I understand that in the event of an outbreak, potential pandemic or epidemic of a vaccine-preventable disease, the University may order this student's/my exclusion from school, for their/my own protection, until the danger has passed.

\_\_\_\_\_ I agree to engage in reasonable risk mitigation practices as required by the University (including the use of PPE, entry testing, and submission to regular screening tests).

\_\_\_\_\_ I agree to immediately notify the University Health Center if I test positive for a vaccine preventable disease or have a known or suspected exposure to someone with the disease.

\_\_\_\_\_ I understand that I may be asked to leave campus to isolate or quarantine if required by the University or the Department of Health.

\_\_\_\_\_ I understand that in the event of an outbreak, I may be asked to leave campus for my own protection and the protection of others until the danger has passed.

\_\_\_\_\_ I agree to assume the risk that I may be exposed to, and become sick from a vaccine preventable disease and to hold the University and its employees harmless from the consequence or effects caused by such an illness.

\_\_\_\_\_  
Signature of student

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of parent or guardian if student under 18

\_\_\_\_\_  
Date