University of CINCINNATI

Vaccination Requirement - Medical Exemption

Student: You may exempt for Medical reasons. Complete and sign this form. Your medical provider must complete the Medical Exemption Requested section.

Upload the completed form to MedProctor. *This form is not to be used for COVID-19 exemptions. Those exemptions go through a separate process.*

Last Name First Middle

DOB (MM/DD/YYYY) University ID Number Semester Start (check one)

M **Fall** **Spring** **Summer** **20_____**

The above named student requests an exemption for the following vaccine(s) (check all that apply and indicate reason for exemption):

- ☐ Hepatitis B Reason_____
- ☐ Measles, Mumps, Rubella (MMR) Reason_____
- ☐ Meningococcal Quadrivalent Reason_____
- ☐ Tetanus, Diphtheria, Pertussis (Tdap) Reason_____
- ☐ Varicella (chickenpox) Reason_____
- ☐ Influenza (FLU) Reason_____

The above-named student understands that by submitting the University of Cincinnati General Exemption form for one or more required vaccines s/he exempts at his/her own risk. The student releases the University of Cincinnati, its faculty, staff, and students from any and all claims connected with an outbreak of disease or other public health immunization emergency on campus. Additionally, the student understands that s/he may be required to leave campus until the situation has been resolved.

Student Signature_____Date ☐☐ ☐☐ ☐☐☐☐

MM DD YYYY

**This exemption may be insufficient for students in the health professions. If you are a student in a UC Health Professional Program such as nursing, medical, etc., this form may not be accepted by your program. UHS will notify you if further information is required.*

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Medical Exemption Requested Section

The below named student requests a Medical Exemption.

Signature of licensed medical provider (MD, DO, PA, NP) and NPI number required.

Last Name First Middle

DOB (MM/DD/YYYY) University ID Number Semester Start (check one)

M **Fall** **Spring** **Summer** **20_____**

TO BE COMPLETED BY LICENSED MEDICAL PROVIDER (MD, DO, PA, NP):

Provider Printed Name _____ Phone_____

Provider Signature/Credentials _____ Date_____

Provider NPI_____

Office Stamp:

**This exemption may be insufficient for students in the health professions. If you are a student in a UC Health Professional Program such as nursing, medical, etc., this form may not be accepted by your program. UHS will notify you if further information is required.*