EXEMPTION FROM IMMUNIZATIONS DECLARATION

Student Health Services • P.O. Box 43692 Lafayette, LA 70504-3692
Phone: (337) 482-1293 Fax: (337) 482-1872

Name: ______________________________________ **Date of Birth:** ____________________________

ULID: _______________________________________ **Semester/Year Enrollment:** _____________________

UL Lafayette email: ___________________________ **Phone:** (______)__________________________

I am requesting an exemption from one or more of the following vaccinations and I am aware of the risks (check all that apply):

□ **MMR 1st dose** □ **MMR 2nd dose** □ **TETANUS** □ **MENINGITIS**

Reason for exemption for the above-referenced immunization(s):

□ **Medical** - If a medical exemption is declared, Student must return the completed Vaccine Exemption Physician Certification Form (attached) to Student Health Services at Patient Portal at ***ull.medicatconnect.com***.

□ **Personal/Philosophical** - If this exemption is requested, state the reason: __________________________________
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Understand the Risks and Responsibilities

Pursuant to Louisiana R.S. § 17:170: In the event of an outbreak of a vaccine-preventable disease at University of Louisiana at Lafayette, the administrators are empowered, upon the recommendation of the Louisiana Office of Public Health, to exclude from attendance unimmunized students until the appropriate disease incubation period has expired or the unimmunized person presents evidence of immunization.

By signing below, I understand that if I declare an exemption, I may be excluded from campus and from classes in the event of an outbreak until the outbreak is over or until I submit proof of immunizations. I understand that if I decline any of the required vaccinations, I continue to be at risk for serious disease. I can always receive the vaccine(s) at any time. I have read and understand the vaccine information from the Louisiana Office of Public Health and the Centers for Disease Control and Prevention and understand risks and responsibilities in exempting/declining the required immunizations.

Student Signature: ____ **Date:** ________________

If student is not 18 years of age, legal guardian must sign below.

Parent or Guardian Signature (if required): _____________________________ **Date:** _________________

Please upload the completed form to the Patient Portal at ull.medicatconnect.com

Find FAQs regarding this form at https://studenthealth.louisiana.edu/immunizations/immunization-compliance-faqs

Vaccine Exemption Physician Certification

I am a physician licensed to practice medicine in a jurisdiction of the United States. By signing below, I certify that for ____________________ (patient name), the following vaccine(s) is(are) contraindicated for medical reasons (check all that apply):

□ MMR 1st dose □ MMR 2nd dose □ TETANUS □ MENINGITIS

The contraindication(s) is(are): □ Permanent □ Temporary

If temporary, the contraindication is expected to preclude immunizations until: Date __________

Physician Information

Physician Signature: ______________________________________ Date: ____________________

Physician Name: ____

Physician Specialty: ____

Physician License Number: ____

Name of Physician Company: ____

Address: ____

Email: ____ Phone: ___________________ ___________