Caltech **STUDENT WELLNESS SERVICES**

VACCINE EXEMPTION APPLICATION

This application is to be completed by a **licensed medical provider (MD, DO, PA, NP).** It is the applicant's responsibility to submit all medical records, labs, and testing to support the diagnosis with this application. Please find our exemption policy here: https://wellness.caltech.edu/health/forms-policies/vaccine-exemption-policy. The student may mail, fax, or send as attachment via the Caltech Student Health Portal, thank you.

MEDICAL PROVIDER INFORMATION			
Provider Name			
License #		**Expiration Date**	
State of Licensure		**Country of Licensure**	
Practice Address			
Phone Number		**Email Address**	
STUDENT INFORMATION			
Student Name			
Date of Birth		**Caltech UID**	
MEDICAL PROVIDER'S CONSULTATION REGARDING THE STUDENT			
Medical Condition:			
Vaccine Name(s) (for exemption)			

Please check the appropriate box(es) and detail in the box provided below:

☐ The applicable CDC contraindication to this vaccine (https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html)

☐ The applicable manufacturer's vaccine insert contraindication to this vaccine, or

☐ The medical circumstances relating to the person such that immunization is not considered safe, indicating the specific nature of the medical condition or circumstances that contraindicate immunization with this vaccine.

Description of Contraindication (*REQUIRED*)

(The medical diagnosis must be an established CDC medical contraindication to the vaccination selected: click here.)

Is this contraindication permanent or temporary?	○ Permanent ○ Temporary: Time period? _____

By signing this form, I hereby certify that the above-named student has a medical condition that contraindicates his/her/their vaccination with the vaccine(s) and that I am able to answer questions regarding this patient and their diagnosis.

Provider Signature		**Date**	

By signing this form, I am requesting an exemption and allowing SWS to review and discuss the information provided with my clinician as needed.

Student Signature		**Date**	