

Request for Medical Exemption to Vaccinations

Student Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

**To Be Completed by Health Provider**

NJ state law ( NJAC 8:57-6.14) indicates that an institution of higher education shall exempt a student from the specific immunization requirements for the stated period of time based on a written statement submitted to the institution by a physician licensed to practice medicine or osteopathy, or an advanced practice nurse in any jurisdiction of the United States, or in any foreign country, indicating that an immunization is medically contraindicated *for a specific period of time*, and setting forth the *reason* for the medical contraindication, *based upon valid medical reasons as enumerated by the 2007 Advisory Committee on Immunization Practices (ACIP), Recommended Child, Adolescent, and Adult Immunization Schedules and the ACIP Recommendations*. When the student's medical condition permits immunization, the medical exemption shall thereupon terminate and the student shall be required to obtain the immunization from which he/she has been exempted. *Above identified guidelines are available from ACIP, US Public Health Service, Centers for Disease Control and Prevention, Atlanta, GA 30333.*

I have examined \_\_\_\_\_ and determined that she/he meets the medical criteria as set forth by the state of NJ to be exempt from receiving the following immunizations.

MMR\_\_ Hepatitis B\_\_ Meningitis\_\_ Covid-19\_\_

Specific period of time the medical exemption is needed.

\_\_\_\_\_ *When the medical condition permits immunization, this exemption shall terminate and the student shall be required to obtain the immunizations from which he/she has been exempted.*

Reason for the medical contraindication based upon valid medical reasons as enumerated by the ACIP.

\_\_\_\_\_  
\_\_\_\_\_ *Objections to vaccinations based on grounds which are not medical in nature and which are of a philosophical, moral, secular, or more general nature are unacceptable.*

**Health Provider Information/Signature**

Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Date: \_\_\_\_\_

**To be signed by student:**

I understand that because of the above stated medical exemption to receiving the specific immunizations indicated I may be temporarily excluded from classes and from participating in institution-sponsored activities during a vaccine-preventable disease outbreak or threatened outbreak.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_