Student Request for Medical Exemption from Immunization Requirement*

***Student Section:* Complete the following information**

Print Name (last, first)_____**Student ID**_____

Email Address:_____ **Best Phone Number** _____

Academic Program: _____ **Student Signature** _____

After you complete this form, scan it and submit it to vaxexemption@campell.edu. Information will be kept only in your confidential student record. You will be notified within seven (7) calendar days after receipt of all necessary information whether your exemption request is approved. *It is the responsibility of the student to report and upload the exemption document into the required portal for the student's program.*

Provider Section: A physician, PA, or NP licensed in the state of North Carolina must complete the medical exemption statement and provide their information below. Forms completed by the employee will not be accepted.
The following are NOT valid contraindications to ANY routine vaccine:

- Egg allergy, even if anaphylactic, is not a valid contraindication to MMR, influenza, or any other vaccine.
- Autism and/or developmental delay in the child or family member.
- Controlled seizures (with or without medication).
- Mild, acute illness (e.g. low-grade fever, cold, upper respiratory illness, diarrhea, otitis media).
- Prior influenza A and/or B infection (influenza vaccine still required for children up to the 5th birthday).
- Contact with immunosuppressed persons by a healthy individual.
- Pregnancy in the household or contact with a pregnant woman.
- Family history of any vaccine reaction(s) or history of allergies (in a relative).
- Family history of seizures (in a relative).
- Parental requests to delay or withhold vaccinations: these requests will not be considered

Physician/Provider: As the student's physician, I request a medical exemption for _____ (student name), date of birth _ _/_ _/ _ _ _ _ for the following required immunization(s). I certify by my signature below that the particular immunization(s) will be detrimental to the student's health:

☐ Hepatitis B ☐ Hepatitis A ☐ Tdap ☐ Td ☐ MMR ☐ Varicella ☐ Influenza

Explanation for exemption request for each vaccine(s). Please attach supporting documentation if needed.
Diagnosis/Event/Treatment: _____ Date of Diagnosis/Event: _____ Expected Duration of Contraindication: _____

_____

_____

_____

Signature of Healthcare Provider: _____ **Date:** _____

Printed name:_____**Practice name**:_____
Practice telephone number:_____Practice email:_____

Students with an approved exemption may be required to comply with preventative measures such as masking and other health and safety protocols by virtue of their unvaccinated status that may not apply to vaccinated students. This treatment is based solely on their unvaccinated status and may be required to protect their health and the health of the Campbell University community.

University Approved: ___ Yes ____ No / Approval: _____**Date:** _____

*For COVID-19 Vaccine Requirement, use form "Student Request for Medical Exemption from COVID-19 Vaccine Requirement"