

**Southern Illinois University Edwardsville
Health Service
Physician Statement for Medical Exemption**

Date _____

Printed Name of Applicant _____ ID# _____

I, the undersigned do hereby request exemption from immunization as recommended by my physician. I understand that in the event of an outbreak of measles, mumps, rubella, meningitis, or diphtheria, I will be required to leave the campus.

Signature of Applicant _____

The above named applicant has requested medical exemption from immunization. Immunizations are required by the State of Illinois. Every student attending a public school must comply. However a medical exemption is acceptable under the following conditions. **The law states that the student must present a written signed, and dated statement from a physician stating the specific vaccine(s) contraindicated and the duration of and the specific medical condition that contraindicates the vaccine(s).** Your assistance is required for medical exemption of the applicant.

1. Immunizations which require exemption _____ Tetanus/Diphtheria/Pertussis
(please check *only* those that apply) _____ MMR
_____ Hepatitis B
_____ Meningitis ACWY

2. Specific medical reason for exemption

3. Duration of exemption _____
(3 months allowable for attempting pregnancy or breastfeeding infant)
If pregnant, EDC _____

Signature of physician _____

Printed name of physician _____

Address _____

Telephone _____