Student Health Services 501 Crescent Street New Haven, CT 06515

Medical Exemption to Immunization Requirements

Name (Last, First, MI)	
Date of Birth	**Banner ID#**
Home Address	**Cell Phone #**
Date Entering SCSU	**Date Expected Graduation**

Exempt immunization/Testing (Check all that apply)

☐ **Measles** ☐ **Rubella** ☐ **Mumps** ☐ **Varicella** ☐ **Tuberculosis** ☐ **Meningitis** ☐ **Covid-19** **Other**_____

Statement of Medical Exemption to Immunization

The physical condition of the above-named individual is such that immunization would endanger life or health.

I certify that I have reviewed the CDC criteria for contraindication to the vaccine and that these are the criteria that have been met:

_____

_____

_____

This exemption is likely to be : Permanent ____ Temporary until the following date: ____

_____

_____ Date_____

Healthcare Provider (MD, APRN, PA) Signature

_____

_____

Print Name, Title and Address of Provider or stamp

I understand that exemption for medical reasons subjects me to exclusion from campus in the event of an outbreak of a disease for which immunization is required.

Signed_____ Date_____

Signed_____ Date_____

Parent or guardian if student is under 18 years of age.

The original of this form is to be scanned and uploaded to your student health portal at https://patient-southernct.medicatconnect.com/login.aspx