

University of the District of
Columbia University Health Services
4200 Connecticut Ave N.W. Building
44 ~ Suite A 39 Washington, DC
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Telephone (202)274-5030
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STATEMENT OF EXEMPTION TO IMMUNIZATION LAW
MEDICAL

Student Name _____ Student ID# _____

I, _____, hereby certify that the administration of

(Physician)

the following vaccine(s) or other immunizing agents are contraindicated by the physical condition of the above named student such that immunizations would endanger life or health:

- | | |
|-------------------------------------|--|
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Tetanus | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Pertussis | <input type="checkbox"/> Rubella |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Varicella | <input type="checkbox"/> Meningococcal |

Other: specify _____

Reason for contraindication:

How long is/are immunizing agent(s) medically contraindicated? _____

Physician's Signature and Stamp

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