University of Virginia | Department of Student Health and Wellness

MEDICAL EXEMPTION

***Does not apply to Tuberculosis (TB) Screening/Testing**

Student Name: _____

University ID: _____ Date of Birth: ____/____/_____

As specified in the Code of Virginia §23.1-800, I certify that administration of the vaccine(s) designated below would be detrimental to this student's health. The vaccine(s) is (are) specifically contraindicated because (please specify):

- ☐ DTP/DTap/Tdap
- ☐ DT/Td
- ☐ OPV/IPV
- ☐ Measles
- ☐ Rubella
- ☐ Mumps
- ☐ Hepatitis B
- ☐ Hepatitis
- ☐ Varicella
- ☐ Meningococcal

This contraindication is: ☐ Permanent ☐ Temporary

And expected to preclude immunizations until: Date: ____/____/_____

HEALTH CARE PROVIDER:

Signature of Medical Provider/Health Department Official: _____

Medical Provider Printed Name: _____ **Date:** _____

Address: _____ **Phone:** ____-____-_____

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