

Certificate of Exemption—Medical

Last Name: _____ **First Name:** _____ **Middle Initial:** _____ **Birthdate (mm/dd/yyyy):** _____

Medical Exemption

A health care practitioner may grant a medical exemption to a vaccine as needed if in his or her judgment, the vaccine is not advisable for health reasons. Providers can find guidance on medical exemptions by reviewing Advisory Committee on Immunization Practices (ACIP) recommendations via the Centers for Disease Control and Prevention publication, "Guide to Vaccine Contraindications and Precautions," or the manufacturer's package insert. The ACIP guide can be found at:

www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html

*Please indicate which vaccine antigen(s) the **medical** exemption is referring to. If the patient is not exempt from certain antigen(s), mark "not exempt."*

Disease	Not Exempt	Permanent Exempt	Temporary Exempt	Expiration Date for Temporary Medical
COVID-19				
Diphtheria				
Hepatitis B				
Hib				
Influenza				
Measles				
Mumps				
Pertussis				
Pneumococcal				
Polio				
Rubella				
Tetanus				
Varicella				

Health Care Practitioner Declaration

I declare that vaccination for the disease/s checked above is not advisable for this patient, I have discussed the benefits and risks of immunizations exemption. I certify I am a qualified MD, ND, DO, ARNP or PA licensed in Utah, and the information provided on this form is complete and correct.

 Licensed Health Care Practitioner Name (print) Licensed Health Care Practitioner Signature Date
 MD ND DO ARNP PA Utah License # _____

Student Declaration

I have discussed the benefits and risks of immunizations with the health care practitioner granting this medical exemption. I understand that failure to immunize may result in the inability to be placed at clinical sites, which would also preclude me from completing required clinical coursework.

 Name (print) Signature Date