MEDICAL EXEMPTION REQUEST FOR VACCINATIONS

To request an exemption from required vaccinations, please complete Section 1 below and have your medical provider complete Section 2 before uploading this form into Magnus.

Section 1

Name (print):	Date:
Year entering the school of nursing:	Cell Phone:

I am requesting a medical exemption from the University Of Mobile School Of Nursing's mandatory vaccination policy for the following vaccination(s):

_____

_____

_____

I verify that the information I am submitting to substantiate my request for exemption from the University of Mobile School of Nursing's vaccination policy is true and accurate to the best of my knowledge. I understand that any falsified information can lead to disciplinary action, up to and including dismissal from the program.

I further understand that the final approval of this request will be from the healthcare facility at which I am assigned for clinical participation and not from the University of Mobile School of Nursing.

Student Signature:	Date:

Section 2

Medical Certification for Vaccination Exemption

Student Name: _____

Dear Medical Provider,

The University Of Mobile School Of Nursing, according to agreements with local healthcare facilities with whom we hold clinical contracts, requires the following vaccinations as a condition of this student's clinical participation throughout the program: Hepatitis B, Varicella, MMR, Influenza, and TDaP. The individual named above is seeking an exemption to this policy due to medical contraindications.

Please complete this form to assist the University Of Mobile School Of Nursing and the local healthcare facilities in the reasonable accommodation process for this student.

The person named above should not receive the _____ vaccine due to (please include additional paper if necessary):
This exemption should be: • Temporary, expiring on: __/__/____, or when _____. _____. • Permanent _____

I certify the above information to be true and accurate, and request exemption from the _____vaccination for the above-named individual.

Medical Provider Name (print):	
Medical Provide Signature:	Date:
Practice Name & Address:	Provider Phone: