CHICAGO STATE UNIVERSITY

WELLNESS/HEALTH CENTER

9501 S. King Drive / ADM 131
Chicago, Illinois 60628-1598
Office: 773 995 2010
Fax: 773 995 2953

IMMUNIZATION EXEMPTION – Medical

Patient's Name: _____ Identification Number: _____

Address/City/State/Zip _____ Telephone #: _____

Exemption requested for (mark all that apply):

o Hepatitis B o Polio o MMR o Varicella o Td/Tdap o Meningococcal

In accordance with the College Student Immunization Act, a Chicago State University student may be exempt from applicable immunization requirements as specified in the Act, on medical grounds.
Section 694.200 Medical Exemption

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a)A student may be exempted from one or more of the specific immunization requirements specified in this Part upon acceptance by the designated record keeping office of a written statement by a physician indicating the nature and probable duration of the medical condition or circumstances that contraindicates those immunizations, identifying the specific vaccines that could be detrimental to the student's health.

b)Female students may be granted temporary exemption from immunization against measles, mumps, and rubella under subsection (a) if pregnancy or suspected pregnancy is certified by a written physician's statement.

c)If a student is on an approved schedule of receipt for any required vaccine, the student will be granted temporary medical exemption for the duration of the approved schedule.

d)If a student's medical condition or circumstances later permit immunization, the exemptions granted under subsection (a), (b) or (c) shall terminate and the student shall be required to obtain the immunizations from which the student has been exempted.

Physician Remarks:

Exemption Petition Continued

I _____ am aware of the need to comply with Illinois Department of Public Health Part 694 College Immunization code.

I am requesting exemption due to the following:

- ❑ Medical Waiver – Medical exemption **must** accompany documentation from your primary care provider and/or waived by the Wellness/Health Center
- ❑ Pregnancy – EDC _____
- ❑ Medical Condition _____
- ❑ Enrolled for less than 6 hours in correspondence courses.

_____ _____

Signature of Student **Date**

Provision of information: I have provided the above named individual, parent or legal guardian with information regarding 1) the required examinations, 2) the benefits of immunization, and 3) the health risks to the student and to the community from the communicable diseases for which immunization is required in Illinois. I understand that my signature only reflects that this information was provided; I am not affirming the named individual, parent or legal guardian's religious beliefs regarding any examination, immunization or immunizing agent.

Required Healthcare Provider Verification and Stamp Required	
HEALTH CARE PROVIDER (MD,DO,APN,NP,PA,RN,PLN,PharmD) **VERIFY IMMUNIZATIONS WERE GIVEN**	
Provider Name (print):	Signature and credentials: Date:
Address (including City/State/Country/Zip or Postal Code):	Phone:

Submit the completed petition to the Chicago State University Wellness Center

❑ Approved _____CSU Healthcare Provider Signature _____Date

Medical Waiver Approval Period _____ to _____

❑ Not Approved _____CSU Healthcare Provider Signature _____Date

***Medical exemption subject to annual review.