LIBERTY UNIVERSITY | STUDENT HEALTH RECORDS

MEDICAL EXEMPTION

Physicians signature required

This form is NOT for medical and nursing students.

Student Name: _____

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

I certify that administration of the vaccine(s) designated below would be detrimental to this student's health.

- Δ Hepatitis B
- Δ Meningococcal ACWY
- Δ Tdap
- Δ MMR
- Δ Polio

This contraindication is: ____Permanent ____Temporary

HEALTH CARE PROVIDER:

Signature of Medical Provider: _____

Medical Provider Printed Name: _____ Date: _____

Completed by the student (and legal guardian if student under age 18):

By signing and submitting this form, I certify that I have read the University's information regarding diseases and vaccines found at https://www.liberty.edu/students/health-services/student-health-records/. I understand that I might be exposed to others who may be carriers of disease, regardless of their immunization status, and I understand that I am assuming the risk of infection. Furthermore, in the event of an outbreak, I understand that the University reserves the right to exclude me from campus until the outbreak subsides.

Student Signature_____ Date: _____

Guardian Signature_____ Date: _____