UTM Vaccination Exemption Form

(Download, print, complete and submit to Med+Proctor)

LAST NAME: ___________________________ **FIRST NAME:** _______________________________ **MI:** ___

DATE OF BIRTH: ____/_____/_________ **STUDENT ID:** ________________________________

I understand that under Tennessee law and/or University of Tennessee, Martin, policy, enrolled students are required to either be vaccinated against the below stated diseases or to obtain a medical or religious waiver. I have reviewed the CDC website information regarding the indicated vaccinations at https://www.cdc.gov/vaccines/index.html and understand the possible risks of not receiving immunizations include: becoming infected with the disease, death, and transmitting vaccine-preventable disease to others. I agree to hold the University of Tennessee at Martin harmless in the event of any illness or injury resulting from noncompliance with this requirement. I understand that in case of an outbreak of disease, I may be temporarily excluded from classes, residence halls or campus events and that this may not be an excused absence.

Student's Signature: ____ Date: _____/_____/_____

Please complete the appropriate section:

RELIGIOUS EXEMPTION: The following immunization(s) is/are prohibited by my religious beliefs and practices:

___ Measles ___ Mumps ___ Rubella

___ Meningococcal ___ Varicella ___ Hepatitis B Series

Student's Signature: ____ Date: _____/_____/_____

If the student is under age 18, a parent/guardian must also sign

Printed Name of Parent/Guardian: ____

Parent/Guardian Signature: _____________________________________ Date: _____/_____/_____

MEDICAL EXEMPTION: A health care provider MUST complete this section.

The following immunization(s) is/are medically contraindicated:

___ Measles ___ Mumps ___ Rubella

___ Meningococcal ___ Varicella ___ Hepatitis B Series

Reason for Exemption: ____

This exemption shall continue until: ______________________________________

Signature of Health Care Provider: ___________________________________ Date: _____/_____/_____

Printed Name of Health Care Provider: _______________________________ License #: ________________________

Address of Health Care Provider: ____

City: ___________________________________ State: __________ Zip: _________________