

## UTM Vaccination Exemption Form

(Download, print, complete and submit to Medica Patient Portal)

**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: \_\_\_\_\_