University of California **Medical Exemption Request Form**

BERKELEY • DAVIS • IRVINE • LOS ANGELES • MERCED • RIVERSIDE • SAN DIEGO • SAN FRANCISCO • SANTA BARBARA • SANTA CRUZ

Full Name: _____

SID/Employee ID: _____

Date of Birth: _____

I, _____ [Name of licensed MD, DO, PA, NP] have reviewed the University of California Immunization Exemption Policy, and hereby certify that:

The above-named person has a medical condition or contraindication to receiving the following vaccine(s):

For STUDENTS: ☐ MMR ☐ Meningococcal conjugate ☐ Tdap/DTaP ☐ Varicella

☐ Other _____

Please check the appropriate box and list below either

A) ☐ The applicable contraindications or precautions are recognized by the CDC, CDPH, or in the case of internationally administered vaccines, WHO.

B) ☐ The applicable manufacturer's vaccine insert contraindication to this vaccine*, or

C) ☐ The physical condition of the person or medical circumstances relating to the person that are such that immunization is not considered safe, indicating the specific nature of the medical condition or circumstances* that contraindicate immunization with this vaccine*

*REQUIRED: **Description of contraindication:**

_____

_____

_____

_____

_____

This contraindication is: ☐ Permanent or ☐ Temporary: Expiration date of exemption _____

On 8/12/21, the Medical Board of California issued the following statement on Inappropriate Exemptions and providers being subject to disciplinary action:

Inappropriate Exemptions May Subject Physicians to Discipline

The Medical Board of California would like to inform licensees and the public that a physician who grants an exemption without conducting an appropriate prior exam and without a finding of a legitimate medical reason supporting such an exemption within the standard of care may be subjecting their license to disciplinary action. The Medical Board of California encourages the public to file a complaint with the Board if they feel that a physician is granting exemptions inappropriately.

https://www.mbc.ca.gov/News/COVID19-Updates.aspx

_____
Printed Name of Healthcare Provider

_____
MD/DO/PA/NP

Office Stamp
(REQUIRED)

_____
Signature of Licensed Healthcare Provider

_____
Date

Medical License Number*: _____

Once this form is filled out completely and signed by a healthcare provider, please upload to your campus' student health Patient Portal.

*Required

rev.06/22/2023