Immunization Exemptions

Medical Exemption **(IC 21-40-5-4; Valparaiso University Immunization Guideline)**

The Medical Exemption form states the reason for the student's medical exemption and must be submitted with the Request for an Exemption form for the exemption to be approved.

A medical provider or clinic offering immunizations must complete the Medical Exemption form. The exemption must be for a medical contraindication in accordance with the recommendations of the Center for Disease Control Advisory Committee on Immunization practices.
https://www.cdc.gov/vaccines/acip/index.html

The student must complete a Valparaiso University Request for Exemption form.
These forms will be placed in the student's permanent health record.

Religious Exemption **(IC 21-40-5-6; Valparaiso University Immunization Exemption Guideline)**

Religious exemptions to vaccinations must be submitted on the Valparaiso University Request for Exemption form. For approval, the student must include a personal religious protest/explanation statement with a letter of support from a leader from my congregation.

These forms will be placed in the student's permanent health record.

College of Nursing and Health Profession's contracted clinical sites do not accept religious exemptions. Clinicals are required for most CONHP degree tracks.

Philosophical/Personal Belief Exemption

State of Indiana and Valparaiso University does not permit exemptions for philosophical/personal reasons.

NOTE:

Students who are approved for immunization exemption will be required to leave campus if an outbreak of any vaccine preventable diseases listed in IC 21-40-5-2 occurs on or near campus.

Students will not be reimbursed or compensated for lost class time incurred as a result of this leave of absence.

Students have the right to revoke the exemption at any time by providing required proof of immunization or immunity.

MEDICAL EXEMPTION TO IMMUNIZATION

PATIENT"S NAME_____ DATE OF BIRTH_____

ADDRESS _____PHONE_____

TO BE COMPLETED BY A MEDICAL PROVIDER ONLY: (check the box(es) that apply)

1. Measles (rubeola), Mumps, and Rubella (German Measles) vaccine*

- ☐ Has an immune titer (specify date of test); Date: ___/___/___
- ☐ Patient is currently pregnant; Estimate Date of Delivery: ___/___/____
- ☐ History of severe allergic reaction to any component of the MMR vaccine (e.g., anaphylaxis)
- ☐ History of immunosuppression, immunocompromised, or known severe immunodeficiency (e.g., from hematologic and solid tumors, receipt of chemotherapy, congenital immunodeficiency, or long-term immunosuppressive therapy or patients with HIV infection who are severely immunocompromised)
- ☐ Family history of altered immunocompetence

2. Tetanus, Diphtheria vaccine*

- ☐ Has an immune titer (specify date of test); Date: ___/___/___
- ☐ History of severe allergic reaction to any component of the Tdap vaccine (e.g., anaphylaxis)
- ☐ History of unstable neurological disorder or encephalopathy (e.g., coma, decreased LOC, or prolonged seizures)

3. Meningococcal ACWY vaccine*

- ☐ History of severe allergic reaction to any component of the meningococcal ACWY vaccine (e.g., anaphylaxis)

4. Meningococcal B vaccine*

- ☐ History of severe allergic reaction to any component of the meningococcal B vaccine (e.g., anaphylaxis)

5. COVID – 19 vaccine* (for CONHP use ONLY)

- ☐ History of severe allergic reaction to any component of the COVID-19 vaccine (e.g., anaphylaxis)
- ☐ It is ***medically contraindicated*** that my patient receives the COVID-19 vaccine

6. Influenza vaccine* (for CONHP use ONLY)

- ☐ History of severe allergic reaction to any component of the influenza vaccine (other than egg; see *Persons with Egg Allergy*)

Medical contraindication to these vaccines must be in accordance with recommendations of Advisory Committee on Immunization Practices. https://www.cdc.gov/vaccines/acip/index.html. ACIP approved precautions will also be considered.

Provider Name: _____ Date: ____/____/_____

Clinic Name and Address: _____

Phone: _____ Provider Signature:_____

Valparaiso University
Request for Exemption from Immunizations**

I, _____, request an exemption from the
(Student's Name)
immunizations required by the State of Indiana and Valparaiso University. I have read and understand the policy regarding exempt status. I understand that if there is an outbreak of a vaccine-preventable disease on or near campus, that I will be immediately excluded from all campus activities (classes, residence halls, work, extra curricular and co-curricular activities, etc.) upon notification of any case of vaccine preventable communicable disease. I understand that I will not be permitted to return to campus for any reason until cleared by Valparaiso University Health Center and Porter County Health Department to do so (a minimum of one period of communicability of the disease). Further, I understand that the University is under no obligation to compensate me for missed course work.

_____ **I am requesting an exemption for medical reasons. I have attached the Valparaiso University Medical Exemption form which has been completed and signed by my provider (IC 21-40-5-4, Valparaiso University Immunization Exemption Guideline).**

_____ **I am requesting an exemption for religious reasons. I have attached my personal religious protest/explanation statement with a letter of support from a leader from my congregation (IC 21-40-5-6, Valparaiso University Immunization Exemption Guideline).**

Student's Signature

Parent's Signature (if student is under age 18)

Date _____ Valpo ID _____

Submit all forms to MedProctor.com for University review by the second Monday of July for summer/fall and December for spring semester. All forms must be submitted prior to review and are subject to approval.