Request for a WAIVER from the Immunization Requirement

Student Information

Name: _____

Student # _____

Current Mailing Address: _____
Address City State Zip Code

Email Address: _____

Date of Birth: _____ Current Phone _____

Reason for your request:

Medical **Religious** **Philosophical/Personal** **Online Program**

Military/Veteran

Student Signature: _____ **Date:** _____

Health Care Provider Documentation (required for medical request):
I certify that this student has legitimate medical reasons for inadequate immunity because (state reason):

_____

_____

_____ _____
Health Care Provider's Signature/Title/Date Print Name and Title

Address: _____ Telephone: _____

_____

Upload this completed form to your Med+Proctor student account.