

DEPARTMENT OF HEALTH

Vermont's Immunization Rule, adopted pursuant to 18 V.S.A. § 1123, applies to undergraduate students enrolled in colleges and universities. Before entry, students must have the required immunizations unless exempt for medical or religious reasons. In order to claim either exemption this form must be completed and returned to the student health center prior to school attendance.

Students who claim any exemption may be kept out of classes during the course of a disease outbreak if it is determined that such students are at risk for getting that disease and transmitting it to other students. The length of time a student is excluded from classes will vary depending on the disease, and can range from several days to more than a month.

Complete all information below on behalf of the student named. This form may not be altered.

_____ / ____ / ____
 Student first and last name Date of birth

MEDICAL EXEMPTION

Check only the specific vaccine(s) that is or may be detrimental to the patient's health:

<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Td/Tdap	<input type="checkbox"/> Varicella	<input type="checkbox"/> Meningococcal 1 st year dormitory residents only
<input type="checkbox"/> Measles	<input type="checkbox"/> Mumps	<input type="checkbox"/> Rubella	

Reason for medical exemption(s): _____

This exemption will likely continue until: ____/____/____.

The law requires that the student receive the vaccine(s) for which they are exempted when the vaccine(s) is no longer contraindicated.

_____ (____) _____
Print Name of Health Care Practitioner* **Telephone**

_____ / ____ / ____
Signature of Health Care Practitioner* **Date**

*According to Vermont statute, only a health care practitioner authorized to prescribe vaccines may sign the medical exemption form.

RELIGIOUS EXEMPTION

In signing this form I attest to holding religious beliefs opposed to immunizations. I acknowledge that I have reviewed evidence-based educational material provided by the Vermont Department of Health regarding immunizations including: information about the risks of adverse reactions to immunization; information that failure to complete the required vaccination schedule increases risk to the person and others of contracting or carrying a vaccine-preventable infection; and information that there are persons with special health needs who are unable to be vaccinated, or who are at heightened risk of contracting a vaccine preventable communicable disease, and for whom such a disease could be life-threatening. I request exemption from the vaccine(s) checked below:

<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Td/Tdap	<input type="checkbox"/> Varicella	<input type="checkbox"/> Meningococcal 1 st year dormitory residents only
<input type="checkbox"/> Measles	<input type="checkbox"/> Mumps	<input type="checkbox"/> Rubella	

_____ (____) _____ / ____ / ____
Signature of Student (or parent if under 18 years) **Telephone** **Date**