WINTHROP UNIVERSITY | Center for Student Wellness

Immunization Waiver - Medical Contraindication

Student Name: Date of Birth: WU ID:

I certify that the individual listed on this form, and in my medical care, is exempted from receiving each of the vaccines listed below for a **MEDICAL REASON**.

Vaccine(s)	Date Exemption Expires	*Or* Permanent Exemption	Medical Reason(s)
	/ /	[ ]	
	/ /	[ ]	
	/ /	[ ]	
	/ /	[ ]	

_____

Healthcare Provider's Printed Name (please print or stamp) Signature Date

_____

Address City State Zip

_____

Phone Number

Student:

I, (print student name) _____, understand that in the event of an outbreak of a vaccine-preventable disease for which I have not been immunized, I may be excluded from Winthrop University. I understand that the University will not be responsible for any classes missed and any fees paid are not refundable.

Student Signature: _____ Date: ____/____/____