



## IMMUNIZATION WAIVER RELIGIOUS EXEMPTION NOTARY FORM

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ WU ID: \_\_\_\_\_

Winthrop University **requires** the following vaccines for admission:

Required	Declined
MMR 2 doses (or equivalent)	<input type="checkbox"/>
Td/Tdap	<input type="checkbox"/>

I have read the Vaccine Information Statement from the Centers for Disease Control and Prevention explaining the vaccine(s) and the disease(s) it prevents. I have had the opportunity to discuss this with the University Health Services nursing staff, who have answered all of my questions regarding the recommended vaccine(s).

I understand the following:

- The **purpose** of and the need for the recommended vaccine(s)
- The **risks and benefits** of the recommended vaccine(s)
- If I do not receive the vaccine(s) according to the medically accepted schedule, **the consequences** may include:
  - Contracting the illness the vaccine should prevent. The outcomes of these illnesses may include one or more of the following: pneumonia, illness requiring hospitalization, brain damage, paralysis, meningitis, seizures, deafness and death. Other severe and permanent effects from these vaccine-preventable diseases are possible as well.
  - Transmitting the disease to others.
  - **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.**
  - **Winthrop University will not be responsible for any classes missed and fees paid are not refundable.**

Winthrop University Health Services staff, the American College Health Association, the American Academy of Pediatrics, the American Academy of Family Physicians, the Centers for Disease Control and Prevention, the South Carolina Department of Public Health all strongly recommend that the vaccine(s) be given according to recommendations. **Nevertheless, due to religious beliefs, I have decided at this time to decline or defer the vaccine(s) recommended, as indicated above, by checking the appropriate box under the column titled "Declined."**

I know that failure to receive the recommended vaccinations may endanger the health or life of myself and others with whom I might come into contact.

I know that I may readdress this issue with the University Health Services nursing staff at any time and that I may change my mind and accept vaccination anytime in the future.

I acknowledge that I have read this document in its entirety and fully understand the information.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Nursing Staff:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**AFTER meeting with Health Services nursing staff this document must be notarized and then returned to Health Services to be reviewed by nursing staff and scanned into Patient Portal.**



Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_

WU ID#:

Address:

Sworn and subscribed before me

This \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_

\_\_\_\_\_  
Notary Public Signature

Seal

**OFFICE USE: when scanning into EMR, please circle the seal made by the Notary Public.**

***Immunization Waiver Medical Contraindication***