|  |
| --- |
| **Request for a Medical Exemption to SFSU Immunization Requirements** |

San Francisco State University (SFSU) policy requires that all students ages 18 and younger are required to provide proof of full immunization against hepatitis B (HepB) prior to enrollment per California Health & Safety Code (HSC), Sections 120390-12039.7. All new incoming students are also required to complete tuberculosis (TB) risk screening questionnaire, as recommended by the CDC, American College Health Association (ACHA), and California Department of Public Health (CDPH). For students seeking eligibility for SFSU Campus Housing, SFSU students are required to complete the requirements for all students as indicated above (i.e. HepB & TB), and provide proof of full immunization for the following immunizations, in accordance with California Department of Public Health (CDPH) recommendations and the CDC: measles, mumps, rubella (MMR); varicella (VAR); tetanus, diphtheria, and pertussis (Tdap); COVID-19; meningococcal ACWY; and, hepatitis B.

|  |  |  |
| --- | --- | --- |
| **PART I – TO BE COMPLETED BY SFSU STUDENT** | | |
| Student Name | | Date of Request |
|  | |  |
| SFSU ID | | Date of Birth |
|  | |  |
| I am requesting a medical exemption for the following vaccine(s): | | | |
| |  |  | | --- | --- | | 🞏 Measles, mumps, rubella (MMR)  🞏 Varicella (VAR)  🞏 Tetanus, diphtheria, & pertussis (Tdap) | 🞏 COVID-19  🞏 Meningococcal ACWY  🞏 Hepatitis B | | | | |
|  | | | |
| Please initial each of the acknowledgements below: | | | |
|  | | | |
| \_\_\_\_\_ | I certify that I qualify for a medical exemption and acknowledge that any medical exemption (including mental health) must be verified by a licensed healthcare professional. | | |
| \_\_\_\_\_ | I acknowledge that I may be expected to provide supporting documentation to this effect immediately upon request from a licensed healthcare professional that describes the medical (including mental health) condition which is the basis for the exemption. | | |
| \_\_\_\_\_ | I acknowledge that unvaccinated persons are at increased risk of developing any of the conditions for which immunizations are required, if exposed to any of these diseases. | | |
| \_\_\_\_\_ | I understand that I may be required to take additional health measures by the University, or the local health authority during outbreaks based on my immunization status. This may include, but is not limited to wearing additional personal protective equipment, such as facial coverings, regular testing, or modification of participation in University in-person activities or attending classes. | | |
| \_\_\_\_\_ | I acknowledge that I may change my mind at any time and submit documentation of a completed vaccination series and nullify this exemption. | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **ATTESTATION** | | | | |
| I confirm that the information that I have provided is accurate and truthful to the best of my knowledge. I also understand that violations of this policy, including dishonesty may be subject to consequences under the Student Conduct Code, as outlined in procedures in CSU Executive Order 1098, Student Conduct Procedures or employee discipline pursuant to California Education Code Section 89535. | | | | |
|  | |  | |  |
|  | |  | |  |
| Student Signature | |  | | Date |
| **PART II – TO BE COMPLETED BY A LICENSED MD, DO, PA, OR NP** | | | | | |
| The above-named person has a medical condition (including mental health) that contraindicates their vaccination with the following vaccine(s): | | | | | |
| 🞏 Measles, mumps, rubella (MMR)  🞏 Varicella (VAR)  🞏 Tetanus, diphtheria, & pertussis (Tdap)  🞏 COVID-19  🞏 Meningococcal ACWY  🞏 Hepatitis B | 🞏 Permanent  🞏 Permanent  🞏 Permanent  🞏 Permanent  🞏 Permanent  🞏 Permanent | | 🞏 Temporary until date:\_\_\_\_\_\_\_\_\_\_\_\_\_  🞏 Temporary until date:\_\_\_\_\_\_\_\_\_\_\_\_\_  🞏 Temporary until date:\_\_\_\_\_\_\_\_\_\_\_\_\_  🞏 Temporary until date:\_\_\_\_\_\_\_\_\_\_\_\_\_  🞏 Temporary until date:\_\_\_\_\_\_\_\_\_\_\_\_\_  🞏 Temporary until date:\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
|  |  | | | | |
| Please check the appropriate box to indicate the reason for the medical exemption request: | | | | | |
| 🞏 The applicable CDC contraindication or precaution to this/these vaccine(s). | | | | | |
| 🞏 The applicable manufacturer’s vaccine insert contraindication or precaution to this/these. | | | | | |
| 🞏 The physical condition of the person or medical circumstances relating to the person are such that immunization is not considered safe. | | | | | |
|  | | | | | |
| REQUIRED – Describe the contraindication. | | | | | |
|  | | | | | |
|  | | | | | |
|  | | | | | |
|  | | | | | |

|  |  |
| --- | --- |
| **MEDICAL PROVIDER CERTIFICATION** | |
| Provider Full Name | License Number |
|  |  |
| Signature | Date of Signature |
|  |  |