

STUDENT IMMUNIZATION REQUIREMENT EXEMPTION REQUEST

The University of Washington provides exemptions from its Student Immunization Requirement for qualified applicants who receive medical counseling about the benefits and risks of vaccination. Students with approved exemptions are subject to exclusion from campus and/or in-person activities in the event of a vaccine-preventable disease outbreak.

This form is required for students requesting an exemption from UW Student Immunization Requirement and must be completed by a licensed health care provider (MD, DO, ND, ARNP, PA, or RN).

Students who participate in the UW **Health Sciences Immunization Program (HSIP)** may only use this form to request exemption from the **meningococcal meningitis** immunization requirement.

Patient Name (print): _____ **DOB:** ____/____/____

Student's UW NetID: _____ **Student UW ID#:** _____

Exemption requested from the following immunization(s) (check all that apply):

☐ Measles ☐ Mumps ☐ Meningococcal Meningitis

*Please note: Students who participate in the UW **Health Sciences Immunization Program (HSIP)** may only use this form to request exemption from the **meningococcal meningitis** immunization requirement.*

VACCINATION MEDICAL COUNSELING

Dear Provider,

The University of Washington requires that students be vaccinated against measles, mumps and meningococcal meningitis. It is recognized that some students may choose to claim an exemption based on medical, religious, personal or other reasons or beliefs that are in conflict with our vaccination requirements. To be eligible for exemption, students are required to review the benefits and risks of vaccination with a licensed healthcare provider and to document the medical counseling as noted below.

Please complete this section and return it to your patient, who will submit it according to the instructions below.

Health care provider declaration:

I have discussed with the student named above the benefits and risks of vaccination. I am a qualified MD, DO, ND, ARNP, PA, or RN and the information provided on this form is complete and correct.

Provider signature: _____ Printed Name: _____

Date: ____/____/____ Select your license type: ☐ MD ☐ DO ☐ ND ☐ ARNP ☐ PA ☐ RN

License #: _____ State: _____ NPI #: _____

Name of medical facility: _____

Address: _____ Phone number: _____

SUBMISSION INSTRUCTIONS

All students seeking exemption must submit this completed form to the Immunity Verification Program.

immunity.washington.edu | immunity@uw.edu | 206.616.4672