Dickinson College Wellness Center
Health Services
Medical Exemption from Immunization Requirements

Name_____ Date of Birth_____

Address_____

SSN_____Telephone_____

Student Statement

I request an exemption from the following vaccination and understand that in case of a communicable disease outbreak I may be temporarily excluded from classes, residence halls, or other campus activities at the discretion of the Wellness Center.

- ❑ Hepatitis B
- ❑ Measles, Mumps, Rubella
- ❑ Meningitis
- ❑ COVID-19
- ❑ Tdap
- ❑ Varicella

Student Signature_____Date_____

Provider Statement

The physical condition of the above named individual is such that immunization would endanger life or health.

____This is a temporary exemption (e.g. pregnancy). Expiration date:_____

____This is a permanent exemption for the following reason:_____

_____

_____

Provider (MD, NP, PA) signature | Print Name (Date) | Date

_____

Address, City, State, Zip | Phone